the MODERN HOSPITAL

VOLUME 59 SEPTEMBER 1942 NUMBER 3

Family Needs Come FIRST

A Wartime Message to Gumpert's Family of 50,000 Regular Customers

By D. Gumpert
PRESIDENT, S. GUMPERT CO., INC.

YOU thousands of REGULAR customers—YOUR needs come first with us these wartime days. In return for your loyalty, we are engaged in an all-out effort to KEEP YOU SUPPLIED and serve your increased wartime needs.

Until brighter times, we regret that no new customers can be accepted.

Long before the current market situation in commercial foods, Gumpert was preparing and planning to take care of its own regular customers' requirements. Being the world's largest commercial food organization, we are in a well "fortified" position to make good our pledge of products and service to you. We are armed with a fifty-year tradition of matchless food knowledge in our field . . . of always being able to do the "impossible".

To help "see the Gumpert family through," we have reserves of materials, plant, financial resources and food-service ingenuity geared to anticipate and meet changes and emergencies. Our experts are busy creating new products and new packages to replace materials no longer available.

A family with a good provider—even in time of scarcity—is fortunate.

S. GUMPERT CO., Inc.
OZONE PARK NEW YORK

CONTENTS

For September 1942

Trustee Forum

Plant Operation and Maintenance

Food Service

Hospital Medicine and Pharmacy

Regular Features

Just in Passing—

AS INDICATED elsewhere in this issue, opinion in the hospital field is that the A.H.A. convention this year is more important than ever before. The program and full details will be presented in our next month's issue together with carefully compiled and organized information about the important hospital developments worth seeing in St. Louis.

HOW do hospital administrators feel about the basic issues presented by the proposal to include hospitalization benefits in the Social Security program? Some surprising results of a poll of administrators on these issues will appear next month.

THE conservation of supplies and equipment is becoming more vital daily. Specific details as to how to save rubber goods commonly used in hospitals will be a feature of next month's issue. Another timely article gives the suggestions of dietitians on methods of meeting the problem of turnover of personnel.

for BETTER STAFF WORK

Your department heads need information in this issue. You can call it to their attention easily with the coupon below. Just tear it out and paste or clip to the cover of the magazine.

READ AND PASS ALONG

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Dietitian	.....	.....
Housekeeper	.....	.....
Pharmacist	.....	.....
Engineer	.....	.....
Laundry Manager	.....	.....
Radiologist	.....	.....
Pathologist	.....	.....
Chief of Staff	.....	.....
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Return to .....

The Modern Hospital

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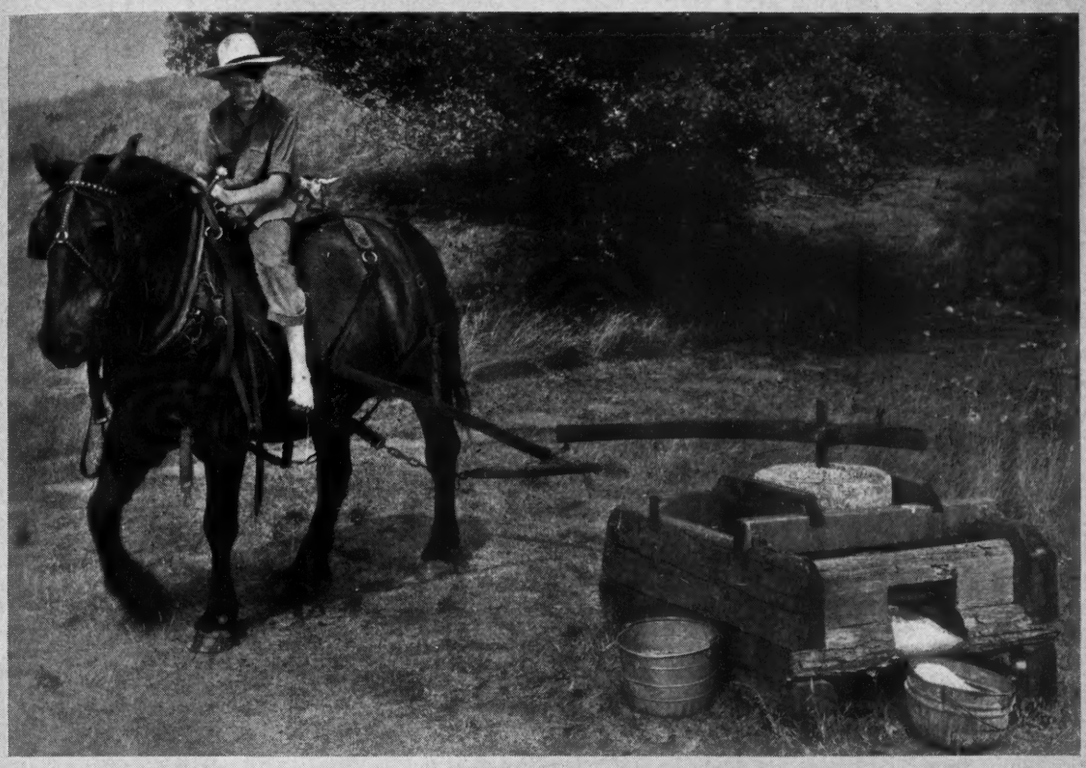

A DEEP MEANING OFTEN LIES IN OLD CUSTOMS

(Schiller)

METHODS formerly used in preparing food may seem crude in comparison with modern procedures, but the old customs had much in their favor. Foodstuffs were only roughly processed, and since loss during preparation was materially less than it is today, diets were richer in vitamins, especially the B group.

In these days it often may be necessary to supplement the dietary with a vitamin preparation of known potency to be assured of an adequate intake. Pulvules 'Beta-Cevalin Compound' (Vitamins B_1, B_2 Complex, and C, Lilly) are particularly suitable for this purpose.

Each Pulvule Contains:

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With other factors of vitamin B_2 complex from liver-stomach concentrate

DOSAGE—1 to 6 pulvules daily as directed by the physician

Supplied in bottles of 40 and 500

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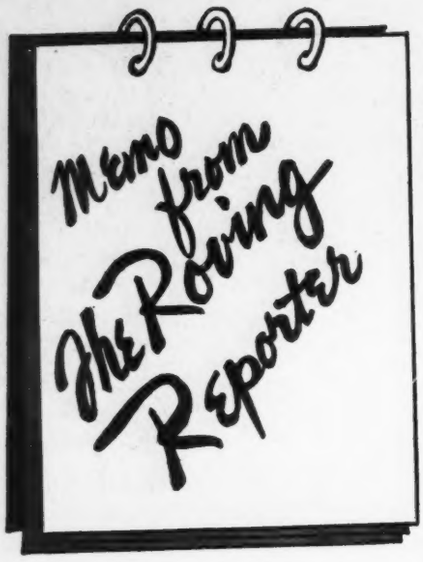

To Encourage Bequests

Recently we made mention of the desirability of issuing pamphlets giving concise information on the matter of hospital bequests. In a recent mail comes a dignified and informative statement prepared by the South Baltimore General Hospital for the use of trust company officials and lawyers in the city of Baltimore. It has created considerable interest, E. Reid Caddy, director, tells us, and is responsible to date for at least one small inheritance.

For his title page Mr. Caddy has selected the line, "As Long as Ever You Can," taken from the inscription on an old headstone in Shrewsbury, England, which reads, "Do all the good you can, to all the people you can, in all the ways you can, as long as you can." Beneath it is a simple explanation: "A statement for persons who wish their money to become a lasting means of human benefit."

The opportunities for bequests ranging from $100 to $50,000 are described, these being followed by a brief account of the work done by the hospital and the area it serves. In the closing paragraphs it is suggested that "a member of the board will be glad to arrange personally to discuss details of bequest opportunities with interested persons or their legal or financial representatives."

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Englewood's "Hospitalers"

In these days when hospital volunteers are being organized and trained on such a large scale, it is significant to note what Englewood Hospital, Englewood, N. J., has done in enlisting "aids" from local high school boys. Every Saturday morning groups of students report at the hospital for instruction as well as for service.

Every man should know something about stretcher bearing, Victoria Smith, superintendent, believes. This is first among the lessons taught. The boys are then told what to do should they be sent to the splint room to get splints. As part of their duties they wheel patients to the physical therapy department and run errands. Not only do they acquire knowledge that will help them in later years but they have proved valuable in assisting about the hospital. Incidentally, being a "hospitaler" has become a real distinction among the student group.

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Labels on Switches

There is no question as to which switches should be turned off or on during periods of blackout in Orange Memorial Hospital, Orange, N. J. On each plate Stanley Howe, director, has had affixed small tags announcing in red letters, "Turn On in Blackout"; or in black, "Turn Off in Blackout." Each sticker is pasted securely over the plate and varnished to assure its presence for the "duration."

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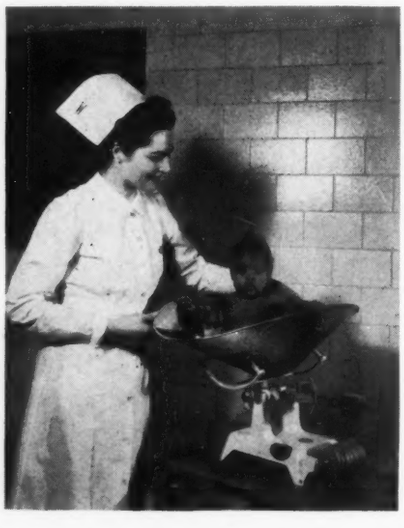
Keep 'Em From Rolling

Some babies rolled and some climbed off the flat type of scale so that, after long wrinkling of brows and arguments with manufacturers, Children's Memorial Hospital, Chicago, made weighing a procedure less taxing for nurses and less hazardous for small patients by affixing an ordinary sugar scoop to the scale.

Mabel W. Binner, the administrator, reports that the sugar scoop scale is now used exclusively in both the hospital and clinic. To show how well the baby fits, just glance at the accompanying photograph of a youngster who looks somewhat reminiscent of Corp. Joe Louis Barrow, now of the U. S. Cavalry.



Keeping Rates in Harmony

Chairman Joseph C. Doane of our editorial board sends a good suggestion from Philadelphia. There your administrator friends, Buerki, Goodfriend, Hatfield, Parkinson, Prentzel, Smelzer, Wilson and Doctor Doane meet as a discussion group to talk over salary trends.

These men endeavor to act in concert so that when one hospital raises nurses' salaries the others attempt to do the same thing, thus eliminating dangerous competition among hospitals in the same locality.

"There may be no more than two or three members of such a group in your own community," declares Doctor Doane, "but meeting regularly for discussion will still prevent the thing that is most harmful to the hospitals and the public, namely, competition in rates."

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Asks Office History Carbons

Never was there greater need for time and labor saving tricks in the hospital than today. Rochester General Hospital, Rochester, N. Y., has asked its medical staff for material assistance in keeping records. It suggests that all physicians bring to the hospital carbon copies of the case histories of their private patients.

For some time now the members of the nose and throat staff and the obstetrical staff have been doing this and it's a big help.

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Dessertless Days

It sounds like World War I, this idea of "dessertless days," but as carried out at Saint Luke's Hospital, Denver, it is definitely of World War II caliber.

L. Irena Hamilton of the hospital staff had the idea after Uncle Sam started sugar rationing and limited the hospitals to a 50 per cent allowance of the sugar they used during 1941.

Once each week in the nurses' and employes' dining rooms no dessert is served so that the hospital saves outright the amount of sugar that would be used for both dinner and supper desserts on that day.

In order to make the employes realize that the desserts they are sacrificing are for the war effort rather than for the hospital's gain, the hospital invests in war bonds the entire amount of money saved by eliminating desserts on those days.

Then each dessertless day there is a drawing and one nurse or employe gets the war bond for that day.

Small Hospital Questions

Conducted by Gladys Brandt, R.N., Children's Free Hosiptal, Louisville, Ky.; Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; William J. Donnelly, Princeton Hospital, Princeton, N. J., and others

Record for Employe Meals

Question: I should like to know how other hospitals check on every meal served to employes so that the hospital may definitely know the number of meals employes are receiving and also that the employe may know the exact number of meals taken at the hospital for income tax report purposes. The federal tax inspector visiting us some time ago suggested a ticket system, using the same number as the employe's clock number. Since this entails so many tickets, I am wondering if you have a better suggestion.—M.A., Mich.

ANSWER: Set up a chart indicating the names of the personnel in each department and the number of meals to which each is entitled. Have the chart arranged so that the waiter, by a check mark, can indicate that a meal has been served. Recapitulations should be made weekly by the dietitian and a monthly report given to the superintendent. Each employe could then be given a monthly memorandum stating the number of meals received during the month.

This system of checking will probably not be 100 per cent accurate, but certainly it should prevent any wide discrepancies. To avoid later misunderstanding, I suggest that this method of tabulating meals be submitted to your federal tax office for approval prior to its adoption.—WILLIAM J. DONNELLY.

Anesthesia Charges

Question: When the hospital furnishes the gas machine and the anesthesia materials and the local doctors administer the anesthetic, what part of the anesthesia charge should be paid to the hospital?—J.W.M., Ill.

ANSWER: It is my opinion that when a doctor anesthetist gives the anesthetic, using a machine and agent owned and furnished by the hospital, the hospital should not worry in any way about the doctor's fee. He would levy that charge himself. The gas should be charged for on the basis of a metered charge, which should be sufficiently high to pay for the cost of the gas and a reasonable depreciation charge for the machine.—JOSEPH G. NORBY.

Records Must Be Maintained

Question: With the high cost of paper, are hospitals going to cut down on the many medical forms?—E.N., Mich.

ANSWER: There will not be very much cutting down on forms for medical record keeping, but there will be more of a tendency to write on both sides of the form. Generally speaking, cutting down on the forms used would mean cutting down on the recorded data, which would, in many instances, nullify the value of the medical record.

Far and wide today there have not been adequate data recorded in each instance to justify the diagnoses and warrant the treatment and end results. The three greatest weaknesses in our present hospital system are inadequate medical records, poor medical staff conferences for the thorough review and analysis of the clinical work and the lack of proper control of the clinical work. For all three, the management and the medical staff are responsible; fundamental to the thorough review and analysis of the clinical work and the control of the clinical work is the adequate medical record. Hence, any cutting down on forms should not impair their completeness and scientific value.—M. T. MACEACHERN, M.D.

Rates for Nurses Reduced

Question: What reduction do you allow graduate nurses on their hospital accounts?—A.F., Tenn.

ANSWER: Fifty per cent, if they are members in good standing with the hospital alumnae association.—OLIVER PRATT.

Waste Fats Make Soap

Question: We are in search of a formula to convert waste fats into soap. No elaborate process is desired—just a product suitable for cleansing floors and walls.—J.R.A., Tex.

ANSWER: The government is anxious that hospitals should not make their own soap but should turn the fat in to the rendering companies so that glycerin, which is much needed in the manufacture of munitions, can be obtained from it. It is, in fact, encouraging the purchase of soap in order to step up the production of glycerin.

The fat can be sold for as much as five cents a pound. Cooks should be instructed in the methods of clarifying fats in order to conserve the supply as much as possible. Slices of raw potatoes cooked in the fat will help to purify it. When strained through filter paper or a double thickness of cheesecloth, the fat will be ready to use again if it is clear and has no burnt or rancid odor. —ALBERTA M. MACFARLANE.

Insurance for Nurses

Question: Do the greater percentage of graduate nurses have protective insurance?—L.M.H., Mo.

ANSWER: A small percentage of graduate nurses in hospitals carry sickness and accident insurance. The practice is to be found more in the public health nursing field than in the hospital nursing field. Increasingly, hospitals are enrolling their employes (including graduate nurses) in Blue Cross plans, thus giving them hospital care insurance.—JIM STEPHAN.

No Relatives Employed

Question: Do many hospitals employ wives or relatives of staff members? If so, are the results satisfactory?—J.L.P., La.

ANSWER: Hospitals generally do not employ wives or relatives of staff members. The present shortage of help in some areas may impel such practice but it should be of a temporary nature.—WILLIAM B. SWEENEY.

Don't Overlap Duties

Question: What would be the duties of a superintendent of nurses in an all graduate staff hospital where the superintendent and the assistant superintendent are nurses and all floors are supervised by graduate nurses? Is such a person necessary in a 75 bed hospital?—G.S.G., Ohio.

ANSWER: In a 75-bed hospital as described above, a superintendent of nurses is not necessary. There would be too much overlapping of duties for harmony in an institution of this size, since the assistant superintendent's duties would be those of a superintendent of nurses. —JEWELL W. THRASHER.

Discounts for Doctors, Ministers?

Question: Do you admit all ministers and doctors to your hospital as complimentary patients?—A.F., Tenn.

ANSWER: The ministers and doctors now can join the Blue Cross plan and, therefore, there is no need to grant them complimentary discounts. You might, however, give them a private room instead of a ward without making an additional charge. If, for any reason, the doctor or minister cannot avail himself of this protection, he should be given a discount not to exceed one fourth of the amount of the bill.—A. A. AITA.

LOOKING FORWARD

Washington Warns

AN EXCLUSIVE message from Washington to readers of The Modern Hospital published on page 51 of this issue is both alarming and assuring. America as a whole does not realize the seriousness of the present situation, does not yet recognize that we are engaged in total war. "Business as usual" continues the stubborn policy of many with little realization on their part of the real sacrifices that face us. Personal standards and hospital standards cannot be maintained; the sooner we recognize these unpleasant facts the better. Such is the plain language of our government leaders.

At the same time new hope for hospitals rests with Washington officials who recognize the important part played by these institutions in maintaining the health of civilian and military personnel. We have the assurance of Maury Maverick, director of the bureau of governmental requirements, that hospitals will obtain a just allocation of equipment, materials and supplies to maintain their essential services. "Our hospital organization," he says, "under the direction of E. W. Jones, administrator, Albany Hospital, as head hospital consultant in the War Production Board, will do its utmost to maintain a steady flow of the really essential equipment, materials and supplies going to all hospitals in the United States." Mr. Jones, in turn, promises a smooth-working bureau through which all hospital claims can be received, studied and judged. Meanwhile, "Help us and you will help yourselves," he urges. "And, above all else, help the country's war effort by exercising the utmost ingenuity in seeing how successfully we can do without."

Thanks, Mr. Luce

MILTON H. LUCE, special advisor to the health supplies branch for W.P.B., has been appointed acting deputy director for W.P.B. in the Seattle district. It would be ungracious, indeed, if we allowed his transfer to pass without a word of appreciation for what he has done in Washington.

Admittedly handicapped by his complete lack of experience and background in the hospital field, Mr. Luce by his diligence, courtesy and judicious attitude won the respect and confidence not only of his colleagues in W.P.B. but of those in the hospital field who had occasion to deal with him. This magazine, through its representative in Washington, has had a great many contacts with various government offices, particularly W.P.B. Often when difficult questions were presented, other W.P.B. officials would say, "I don't know; you'd better see Mr. Luce." And Mr. Luce either knew or found out. Good luck, Mr. Luce, and thanks.

Conventions in War Time

AS REPORTED elsewhere in this issue, our suggestion regarding the proper method of reducing the number of conventions has met with an overwhelmingly favorable response from hospital people and from manufacturers and dealers who supply them.

When the matter of exhibits is under consideration, manufacturers and dealers would like to participate in the discussion through a few chosen representatives. Since they "pay the freight," this is a reasonable attitude. Furthermore, the close friendly relations that have existed for many years between them and the hospital field indicate that they will be cooperative in working out any sensible program.

So far the government has merely requested and not demanded that conventions be reduced. But it would be wise to heed the request so that the demand will be unnecessary.

Hotels as Hospitals

IN HARPER'S MAGAZINE for August appears what is described as a practical way to care for air raid casualties. Based on a plan worked out in Moore County, N. C., it proposes the use of local hotels as temporary casualty stations. Each hotel is asked to place two rooms permanently at the disposal of the authorities—one for storing necessary materials, the other to be prepared for use as an operating theater. To quote: "Its most obvious advantages are economy, the use of existing resources and the distribution of responsibility."

Granted that emergency facilities must be patterned to conform to local requirements, there is still grave question as to the practicability of transforming hotels

into hospitals. The fact that they already possess kitchens and laundries does not answer every problem. There remain the questions of passing stretchers through doors that were not designed to accommodate them, of setting up a surgery in any hotel room, of the ability of the hotel laundry to meet hospital needs. And is distribution of responsibility necessarily an advantage?

Hotels serving as casualty stations with schools, town halls and other buildings have a definite place in the emergency program and deserve the consideration of local authorities everywhere. Their transformation into casualty hospitals, however, with independent surgeries and special staffs is another matter. Despite the urgency for adequate emergency measures, the practicability of such a scheme is bound to be challenged.

Medical and Surgical Plans

THE medical profession of New Jersey is to be complimented on the inauguration of a medical and surgical plan that seems to offer a reasonable likelihood of success. From the details now available, summarized in our news columns this month, the plan seems to be a genuine attempt on the part of the physicians to meet a public need.

The New Jersey doctors have wisely arranged with the Hospital Service Plan of New Jersey to handle the enrollment work. This makes the tenth Blue Cross plan that has undertaken to enroll for a medical service plan; others are in Utica, Buffalo, New York City, Pittsburgh, Michigan, Massachusetts, Colorado, California and North Carolina. A similar plan may soon be launched in Oklahoma.

If a medical service plan is formulated in good faith, with reasonable rates and benefits, skillful direction and sound enrollment policies, it is definitely to the advantage of the hospital plan to undertake a joint enrollment. That gives the Blue Cross plan an effective answer to the major sales argument of the commercial insurance plan, namely, that it covers medical and surgical expense.

However, there is great danger to Blue Cross plans if they tie themselves up with plans that are not completely "on the level." The public relations of the medical profession have been, on the whole, rather poor for the last ten or fifteen years. Hospitals will be tarred with the same brush if they help to promote plans that do not meet the true needs of the public.

A Thought for the Salesman

THE salesmen who call on our hospitals today are facing unusual problems. Some of them have had to give up their automobiles and use overcrowded buses or trains, which are often behind schedule. Many of them have had to take on extra territory to fill in for colleagues who have gone to war or war industries. All of them have found their jobs tremendously complicated by the shortages, substitutes, delayed deliveries and other factors unavoidably associated with our conversion from a peace-time economy.

All hospitals must realize, as most of us already do, that we are living in a seller's market. We have more advantage to gain from the salesman who calls on us than he has. If we give him an order, it may be just another headache. Yet he may be able to give us ideas and suggestions that are extremely helpful in making the most of what we have or what we can obtain.

Under these circumstances it behooves us more than ever to be considerate of the salesman's comfort and, particularly, his time. While we have to have some kind of interviewing hours, because our own problems have so heavily multiplied, we ought to arrange these hours to meet the needs of the salesmen. Furthermore, we ought to be a little flexible in enforcing the hours. If we cannot personally see the salesman who calls out of hours, we can make arrangements for our secretary or someone else to see him, hear his story briefly and, if indicated, refer him to an appropriate department head. We shouldn't ask him to retrace his steps and make unnecessary repeat calls. This not only takes up his time but wastes transportation facilities.

Women in Medicine

THE story of women in medicine over the years is one of dauntless persistence in overcoming professional prejudice and public distrust. There is increasing evidence, however, abetted by the exigencies of war, that the heart-breaking efforts of the early pioneers have not been in vain. A recent statement from New York Hospital reveals 72 women on its staff as compared with four twenty years ago. Coincident with this revealing information, a Pennsylvania hospital announces the appointment of a woman to head its medical staff in place of a doctor called to war. Day to day reports on intern placements also indicate that women are finding doors open to them that formerly were closed.

Not content with these new opportunities to reveal their skill and stamina in posts at home, crusaders among women in medicine are casting their eyes upon the scene of battle. A recent appeal by women physicians to the President and to Surgeon General James B. McGee asks full membership in the Army Medical Research Corps. Memories of the grade of contract surgeon at base hospitals, which they were accorded in the first World War, still rankle. They wish to be commissioned "according to their preference and professional capabilities."

As dramatic as the rôle of Army doctor unquestionably is, the women would do well to consider that equally distinguished opportunities await them at home.

WAKE UP, AMERICA!

SAYS MAURY MAVERICK

The director of the bureau of governmental requirements warns that "business as usual" is taboo in these critical times. But there's a bright side, too, to the hospital picture

RAYMOND P. SLOAN

MAURY MAVERICK

WINNING this war should be the first consideration of every man, woman and child in America today. We haven't begun to make the sacrifices that will be required of us.

Despite the frequent reiteration of these warnings, there are many who stubbornly adhere to the "business as usual" policy with the war program as a side line. It is their attitude that concerns Washington officials. Unless America wakes up, there is grave danger that we shall be fighting alone to defend our very shores, they insist.

Prominent among the heads of government departments who are raising their voices in the plea, "wake up, America," is Maury Maverick, director of bureau of governmental requirements. In an exclusive interview with a representative of The Modern Hospital this dynamic, colorful and hard-hitting citizen from San Antonio, Tex., expresses the firm conviction that few of us are really awake to the seriousness of the situation. Never one to spare punches, Mr. Maverick states forthrightly that we are in a total war which will require real sacrifices in our personal lives and in our hospital standards, too.

Hospitals are fortunate, however, in having in such a strategic post one who is sympathetic to their pressing problems. "I have been in the forefront of legislative efforts to promote science and health legislation in this country," Mr. Maverick explains, "and I know the value to all of us of sound medical care, research and education for our people. Without a healthy group of civilian workers and producers the war cannot be carried on successfully. Our great group of American hospitals is indispensable in maintaining civilian and military personnel on a healthy, top-fighting and top-producing level.

"Whereas our first responsibility is the conservation of critical materials for the armed forces, we must see that hospitals obtain a just allocation of equipment, materials and supplies to maintain their essential services. At the same time hospitals must realize that 'business as usual' cannot be maintained through these desperately critical times.

"Our hospital organization under the direction of E. W. Jones, head hospital consultant of the War Production Board, will do its utmost to maintain a steady flow of the really essential equipment, materials and supplies going to all hospitals in the United States. Every hospital administrator, doctor, nurse, employe and governing board member must practice Spartan economy and relearn the ways and means of doing their jobs with far less equipment and luxury items than they have had in recent years. We must work together to make the best possible use of our American hospitals."

The bureau of governmental requirements under the direction of Maury Maverick is one of several bureaus within the division of industry operations. It acts as a focal

point for assembling and transmitting information on nonmilitary material requirements of all branches of federal, state, county and local government, including governmental agencies engaged in institutional activities. It also deals with material requirements of semiprivate and private institutions, including schools, colleges, churches, hospitals and welfare establishments. It also makes the first recommendations as to the essentiality of all materials, supplies, equipment and construction needs of the agencies and institutions under its jurisdiction.

All applications for priorities and allocations assistance from those agencies within its jurisdiction are considered and recommendations are made to the chief of the bureau of priorities as to the proper issuance of orders and certificates. Recommendations for ratings receive the concurrence of the appropriate end product or materials branch. No order or certificate affecting any governmental agency or private institution is issued except after submission to the governmental requirements bureau for its recommendations, unless by a procedure established by or pursuant to a division administrative order.

The bureau of governmental requirements is divided into several branches, each branch, in turn, being subdivided into sections. This same pattern is followed in the bureau of industry branches where various "end" product and "materials" branches, such as health supplies, iron and steel, plumbing and heating, handle their respective specialties.

If a hospital seeks replacement of boiler tubes, the application is routed from the central mail room direct to the hospital group in the governmental requirements bureau. Depending upon the completeness of the story as given by the hospital on form PD-1A and, possibly, in an accompanying letter giving more details, the analyist working on the applications passes judgment and a certain priority rating is recommended. The application is then routed to a specialist in the iron and steel branch for concurrence. After further study the end product or materials branch assigns a rating to the applicant's request. The application with its rating then goes to the review and approval branch, where a final check is made on the rating previously given. This branch sends the application to "issuance," from where the application is returned to the hospital.

If the group in the bureau of governmental requirements does not feel that a priority rating is justified, the hospital is notified direct. The hospital always has the right to seek a reconsideration of the denial; in the event that the priority rating given is not high enough to get delivery, the hospital may ask for reconsideration.

With the appointment of Everett W. Jones of Albany Hospital as head hospital consultant in the schools and institutions section of the bureau of governmental requirements of the War Production Board, all requests by hospitals for information or preference ratings are now centralized in his office. This is the case whether the hospitals are governmental, voluntary or proprietary. The requests for ratings will be forwarded to other interested branches of W.P.B. with recommendations by the schools and institutions section for approval or denial.

Mr. Jones was graduated in engineering by the University of Wisconsin in 1923. He served as a sergeant in the U. S. Army Medical Corps in the first World War. Following college he was an engineer with Western Electric Company and John A. Manning Paper Company. He went to Albany Hospital as general superintendent in 1926 and was appointed director in 1935.

According to Everett Jones, a study of several thousand PD-1A and PD-200 applications from hospitals in all parts of the United States shows a surprising amount of carelessness in filling out the application forms. This causes a tremendous amount of added work and slows up action on applications. It should be remembered that a PD-1A form is to be used in applying for equipment items, maintenance and repairs and operating items that are indispensable. A PD-200 form is used for a project involving building alterations, construction and additions to existing facilities. If asking for one or more new x-ray machines, certain repair parts, beds or other items where no building alternations, construction or additions are involved, use PD-1A. If, however, these or any other items involve building changes or construction or additions, use PD-200. When in doubt write full details and get advice.

Mr. Jones also suggests that, in addition to filling out the forms carefully and completely, it is advisable to include a letter giving the whole story. "We cannot pass on requests intelligently," he says, "without enough information to make the case as clear to us as it is to you.

"Remember, our first job is to conserve critical material for our armed forces. A little ingenuity will frequently result in doing without the piece of equipment that was thought necessary. All hospitals must economize and 'get along without' as they have never done before. We will, however, do our best to get those things that are absolutely necessary.

"Above all else, be patient. We have a tremendous job in front of us. We are now developing working arrangements with the surgeon general's offices of the Army, Navy and Public Health Services, also the offices of Dr. George Baehr, head of emergency medical service for civilian defense, and Dr. James A. Crabtree of defense health and welfare services, but it is going to take several months to build a smooth-working organization. Help us and you will help yourselves."

☆ Word from ☆ *Our Readers in Service*

From camps and battle fronts come letters from hospital administrators on leave in their country's service. Don't you want to share extracts from some of the lively letters you receive? Any letter published we first send on to Washington for official approval

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HAVE been a reserve medical officer for years and when the Army began to inquire about my availability in the fall of 1940, I decided against deferment and was ordered to Fort Benning, Ga., on December 10.

Was assigned to the surgical service of this Station Hospital and as the regular army officers of the staff were gradually transferred to other stations I was pushed up the ladder until I became chief of the surgical service a few months ago and was promoted to the rank of lieutenant colonel.

The Army has quite a hospital here. I have seen it expanded from the original 250 beds to its present census, and there seems to be no limit. I had 985 patients on surgical service a few days ago. Staff organization is efficient and the medical officers are capable.

We have three services: administrative, medical and surgical. The surgical service is divided into seven sections: general surgical, clean and septic, orthopedic, urological, E.E.T.N., obstetrics and gynecology, and dental.

Each of the sections has a chief responsible to chief of service and the latter to the commanding officer. Each service has a weekly staff meeting together with a meeting of general staff each week. The hospital operates a dozen or so out-patient clinics, six on surgery alone.

I enjoy my work and find Army life an interesting experience. Am even more confined than in civil practice; haven't been able to attend a medical or hospital meeting since I have been here. Accepted an assignment on the program of the Southeastern Hospital Conference in Memphis last April, had my leave and all arrangements made and just a few days before my chief was transferred and I had to take over. There was no question as to what I was expected to do: wire my apologies and stay on the job. That's Army discipline.

We have a social life all our own. The reservation has an expanse of over 150,000 acres and I seldom leave it. We have a population of many thousands with all necessities and most conveniences at our disposal. I have a comfortable home on the post for my family; we have stores, churches, school, theaters. Have an officers' club for social functions, with swimming pools, tennis courts and golf course. I haven't worn a civilian suit in so long that the appearance of one is even beginning to seem strange. That is just a minor example of the changed psychology. In civil life, we strive to be just a little different; in Army life, the sameness of things is rather relaxing.

A good soldier soon learns not to question the future. That again relieves the pressure. We never get too big to take orders and are trained to exert all our efforts to carry them out to a successful completion, promptly. That training alone is of great value in every man's life and gives our psychological trend a good healthy balance. Here today, ordered away tomorrow stimulates us to get the most out of life while the opportunity is at hand.

I have intimate acquaintances in nearly all the combat areas of this war. Some were at Bataan, others are scattered over the various Pacific outposts, in Iceland and in Ireland. I have been able to stay with my family longer than the average but I live from day to day not in anticipation of but ready to accept, at a moment's notice, any orders that may break it up. When that no longer keeps one awake nights he is beginning to get the trend of good soldiering.—A. M. McCarthy, Lt. Col., M.C., *formerly administrator of George C. Hixon Hospital, Electric Mills, Miss.*

July 6, 1942

AM STATIONED at the medical replacement training center at Camp Barkeley, Tex., and am beginning to get on to "Army life," although it does seem to take time. My first two weeks here were spent doing basic training: hikes, drilling, tent pitching and the many other details which go to make up Army routine. I am not sure I have learned everything, as new orders fly around so fast it is somewhat difficult to absorb all the training. Am now completing my seventh week of clerical school during which time we have tried to learn Army office work. We study the manner in which to make out pay rolls, service records, morning reports and the many other records and data pertaining to clerical work.

We will have our graduation exercises Saturday and then hold our breath while waiting to be shipped out. Of course, none of us knows where he will go, but I am hoping that I will be sent to some hospital unit.

I am enjoying Army life and haven't a complaint in the world. The changeover is strange, but once accustomed to the routine, it is really stimulating. The food is good (I have gained 6 pounds); the sleeping is wonderful, and I feel well all the time—so I guess this sort of life agrees with me. — Pvt. John C. Crimen, M.R.T.C., *formerly administrator of Southwestern General Hospital, El Paso, Tex.*

The KENNY TREATMENT

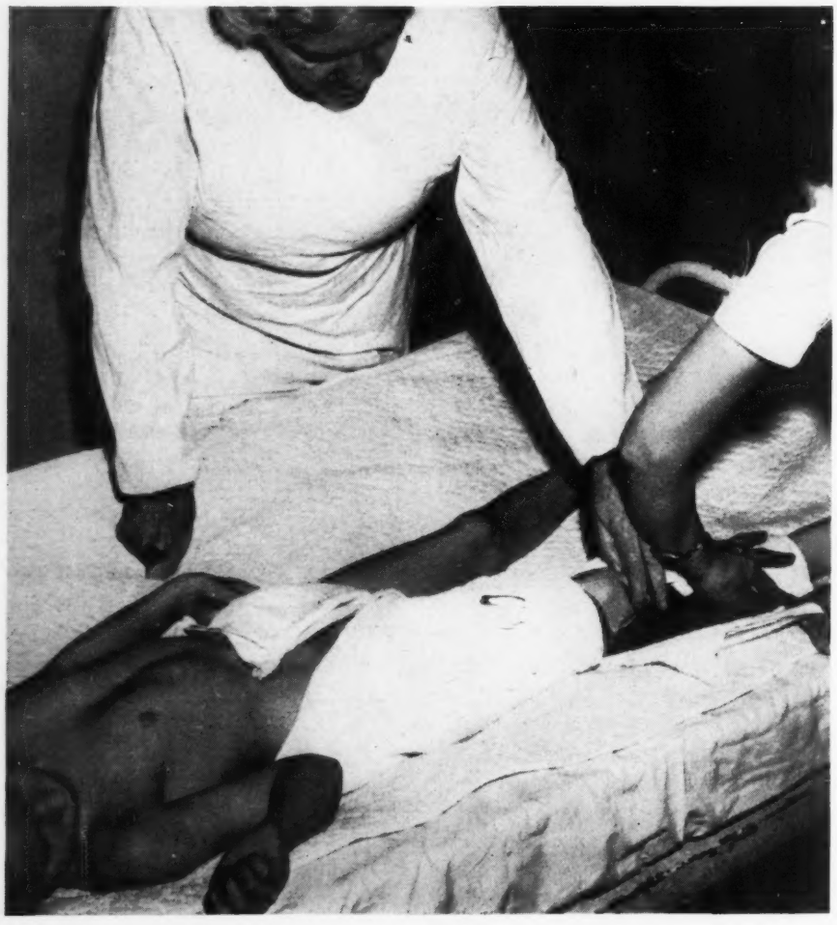
DON W. GUDAKUNST, M.D.
MEDICAL DIRECTOR, THE NATIONAL FOUNDATION FOR INFANTILE PARALYSIS

Requires adequate supplies, skillful technicians and a revised admission procedure for success in general hospitals

MEDICAL innovations are likely to create hospital administration difficulties. The Kenny method of treating acute poliomyelitis certainly has raised some difficult problems that must be faced by the hospitals. As yet these problems are not acute for, as this is written, there are comparatively few cases being reported and there are but few institutions prepared to apply this form of treatment.

The problems will be found in at least three fields: personnel, admission of patients to hospitals and equipment for giving the treatment. These problems are presented not in an attempt to offer a solution but so that hospital administrators can be made aware of their existence. As the Kenny method gains wider use, still other problems may present themselves.

The Kenny method of treatment of acute or early infantile paralysis is radically different from any form of therapy heretofore utilized. It is based upon the major premise that the early primary symptom in most cases is one of spasm of muscles and not that of flaccid paralysis. In the vast majority of cases the manifest inability to contract a muscle is but a pseudoparalysis resulting from pain, spasm or other as yet unde-



Applying hot fomentations to the affected area is the first principle of the Kenny treatment. The wool used must be old, free from oils and fats and fully shrunk. Old blankets are ideal for this purpose.

International News Photos

termined cause. Such pseudoparalysis is termed "mental alienation" by Miss Kenny. A few cases may show a true paralysis owing to extensive destruction of the anterior horn cells, but this is a relatively infrequent state in poliomyelitis infection. Most cases, and certainly all those who make a spontaneous recovery from paralysis, fall into the class of "mental alienation," or pseudoparalysis.

Resulting from the spasm and pseudoparalysis there may be a train of symptoms referred to by Miss Kenny as "incoordination." By this she means that there is an attempt to produce joint motion by use of muscles either incapable of or not intended to produce such motion.

The treatment of spasm, "alienation" and "incoordination" by the Kenny method, in the hands of all who have understandingly and intelligently used it, has given excellent results. There are no evidences in these patients of stiff and immobile joints, of contractures and of trophic ulcers and there is no scoliosis. Miss Kenny claims there is no shortening of legs, but the method has not been utilized long enough in this country to confirm this statement.

The Kenny treatment is divided into two main lines of endeavor. First, there is the application of hot fomentations. This is for relief of pain and the relaxation of spasm. Second, there are the passive and active exercises designed to bring about return of muscle function and coordination of motion.

The hot packs can be administered by nurses with assistance from aides. A team of a nurse and two aides can apply a complete set of packs to one patient in about ten or twelve minutes. Thus, five or six patients per hour can be cared for. These packs must be renewed every two hours for at least twelve hours a day. From 10 to 12 poliomyelitis patients will require, on the average, the services of three persons for twelve hours daily, seven days a week. This provides only the hot pack portion of the treatment, which must be continued for a period varying from several weeks to many months.

Muscle reeducation cannot be well done by nurses unless they have had extensive postgraduate training in physical therapy. This part of the treatment should be administered by a physical therapy technician who has had several months' additional training in the special problems and the methods of this work. As the case progresses, or as the patient leaves the acute painful stage of the disease, the work of the physical therapist increases from a matter of a comparatively few minutes twice a day with each patient to as much as an hour or more daily, depending upon the degree and extent of involvement.

These are tasks that, for the most part, cannot be taken over by unskilled hands. This part of the work cannot be postponed but must be carried out immediately upon diagnosis of the condition. It cannot wait upon the convenience of the hospital, doctor, nurse or therapist. It cannot be spread out over the twelve months of the year as can be done with elective reconstructive orthopedic operations. This work must be carried out frequently under epidemic conditions.

Not only will an epidemic place great demands upon any hospital undertaking the Kenny method, but also it will be necessary to have services for the sterilization and preparation of the hot packs. The cutting, sorting and labeling of this material all must be done under peak-load conditions. Packs cannot be supplied from stock sizes; each patient must have material cut to fit the individual needs. This preparation and maintenance of supplies is no small task.

In addition to this problem of personnel, there will arise in many localities the need for readjustment of hospital admission policies and of communicable disease practices. While the Kenny method of treatment can be administered in almost any home, the demands of even a minor outbreak are such that hospitalization would seem to be a necessity. The nursing and physical therapy services, the physical equip-

This portable wringer and tub arrangement is a necessary part of the equipment. With this unit, a team of one nurse and two aides can apply a complete set of hot packs to five or six patients an hour.

Miss Kenny explains the exercise portion of the treatment, which is designed to bring about the return of muscle function and coordination. Muscle reeducation requires hands skilled in physical therapy and a knowledge of the Kenny treatment.

ment required and the medical supervision of the cases cannot be provided on a home-visit basis. Epidemic conditions call for the maximum utilization of these professional services, which can be accomplished only under a hospital admission program.

In many localities it has been the practice to isolate the acute cases for a required two or three weeks' period, either at home or in a communicable disease hospital. At the end of the legal isolation period patients have been transferred to general hospitals for orthopedic care. Such practice does not fit in with good Kenny treatment, for this type of care must be started far earlier than could be provided under such a setup.

It will be necessary either to transfer physical therapists and specially trained nurses and aides to the communicable disease hospitals or to admit cases in their first days of illness to general hospitals where treatment facilities are available. Either procedure introduces problems that are not too difficult but that must be faced and planned for in advance.

An additional problem is presented by the longer initial hospital stay under the Kenny method. It has been common practice to discharge many patients at or shortly following the required isolation period. Patients were sent to their homes in splints or casts and visited periodically by nurse, physical therapist and orthopedic surgeon. These visits were relatively infrequent and not too time consuming. Under the Kenny treatment patients must be kept in the hospital under special supervision until maximum recovery has taken place, or at least until all spasm, "alienation" and "incoordination" have been overcome. This may require a period of from many weeks to many months.

However, readmission for corrective surgery or prolonged physical therapy care over even many years is not called for except in the small percentage of cases in which permanent paralysis develops. Owing to the absence of contractures and deformities, the reconstructive surgery or brace-fitting program is tremendously simplified. While extensive and accurate figures are not yet available for American experience, it is the opinion of many that the total number of hospital days for the complete care of poliomyelitis will be greatly reduced by the Kenny form of treatment. There will be more concentration of hospitalization days in the period immediately following the onset of illness but there should be a consequent reduction in the amount of hospitalization necessary in the later after-care or reconstructive program.

The third great problem in making this treatment available concerns supplies and materials. While the necessary supplies are neither extensive nor elaborate they are somewhat difficult to obtain in view of the present war demands. The hot pack material must be all wool; cotton is totally unsatisfactory. The wool preferably should be old, well freed from oils and fats and fully shrunk. Old blankets are ideal. Some of the woolen materials used in the paper industry are well adapted for this purpose.

In practice, this material is wrung dry out of boiling water. This calls for portable units consisting of some type of tub on wheels to be moved from patient to patient. To the tub is attached an ordinary clothes wringer. The hot packs are applied to the affected parts and then covered with a lightweight material that is impervious to water, such as oiled silk or some pliable plastic. This, in turn, is wrapped in more woolen blanketing to retain the warmth over a longer period.

These various materials — wools, clothes wringers, plastics—all are on the restricted list and are difficult to obtain. However, if they cannot be procured suitable substitutes can be improvised.

The National Foundation for Infantile Paralysis has sponsored the work of Miss Kenny in this country. She and her staff of assistants have been maintained at the University of Minnesota out of funds made available through the foundation. The medical advisory committees of the foundation have reviewed the results of her form of treatment and have recommended that this method be made available to the people of the United States. To that end training programs have been established by the foundation whereby technicians can be taught and doctors and nurses can be made familiar with their phase of the program. The foundation has been able to procure a limited amount of woolen material, which can be supplied to hospitals using the Kenny method of care for infantile paralysis victims.

In addition to this, the foundation stands ready to render assistance in the form of consultation and advice in preparing and assisting hospitals to meet the problems that arise in the face of epidemic conditions.

Shall We MEET *in War Time?*

Each additional day of war makes this question a more compelling one. Here are 15 views, provoked by the editorial in the August issue of The Modern Hospital

"IMPORTANT conventions are undoubtedly more necessary today than ever before." That comment is typical of the response to the editorial in the August issue of The Modern Hospital calling upon the leaders of the national, state and regional hospital associations to set up immediately a joint committee to work out methods of reducing the number of conventions and of increasing their quality.

While most of the commentators feel that the A.H.A., the organizations that meet with it and the C.H.A. should continue their conventions (as the A.H.A. did during the first World War), they are unanimous in believing that many other meetings can be omitted or consolidated. Also, the continuance of commercial exhibits is seriously questioned.

Nearly everyone believes, apparently, that state hospital associations should either combine in a few strong regional assemblies or omit their meetings.

Dr. A. J. Hockett of Touro Infirmary, New Orleans, for example, writes: "I feel that the hospitals should assist the work of the armed forces by the reduction of meetings as far as possible. However, these are hectic times and I believe that it is advisable for hospital people to get together at important meetings at least twice a year.

"It is my personal feeling that if the hospital conventions were limited to the national in the fall and one meeting each in the East, Middle West, South and West in the spring, this would assist in coordinating our war effort and still not be a serious strain on transportation facilities."

Dr. Robert H. Bishop Jr. of the University Hospitals, Cleveland, says that he is "heartily in sympathy with the move to reduce the number of conventions. No time should be lost in giving this problem serious consideration and every effort should be made to see that such conventions as are held are worth while from every standpoint."

Dr. Robin C. Buerki, former A.H.A. president, says he thinks the suggestion is excellent but asks: "Can it be worked out?"

F. Stanley Howe, director of Orange Memorial Hospital, Orange, N. J., points out that the New Jersey association is to meet with the New York association next spring and suggests this as desirable for other small states not already participating in regional assemblies. He adds a new and constructive suggestion: "If it were possible to finance it, some of the value of convention contacts might be preserved if the association were in a position to supply a few more field representatives who could circulate freely among the hospitals, meeting with small groups or with individual institutions, thus bringing the administrators who cannot get away the information as to what is being accomplished on the problems that most trouble them. A small portion of the money spent on going to conventions might provide this substitute."

Joseph G. Norby, president-elect of the American College of Hospital Administrators, urges that conventions be streamlined:

"Conventions should, I think, be reduced to a minimum during these times. However, I do not believe that it is wise for hospitals to eliminate them entirely. The following plan might be worked out without serious curtailment of effectiveness.

"In the first place, if local or state conventions are to continue, they should be reduced to the minimum in time. Most of these conventions could be cut down to one or, at most, two days with the work starting early and promptly in the morning and continuing without interruption throughout the day and into the evening. The same principle might be applied to regional and national conventions.

"Beyond that it might seem desirable to eliminate state meetings and concentrate on regional meetings only. As far as the national meeting is concerned, it is entirely possible that this could be reduced to a business conference with only the delegates in attendance. In other words, carry out the educational features in regional meetings and attend to business and national affairs through the agency of the delegate assembly. This could also be cut to two or three days."

Dr. Harvey Agnew, secretary-treasurer of the Canadian Hospital Council, presents the following thoughtful comments:

"We must curtail every unnecessary effort and expenditure, not only next year but for several long years. Regional conferences could well replace some of the weaker state and provincial meetings.

"The big problem is that of our national meetings. One hesitates to consider the discontinuance of national meetings even for a few years. Many exceedingly vital matters involving the very existence of our hospitals are now before us and others are likely to arise in the immediate future. War-time emergencies, social legislation, federal con-

trol policies and other matters should be given careful consideration.

"Moreover, the canceling of a meeting is a serious financial loss to the organization because of the exhibit revenue. Once this continuity is broken it is difficult to reestablish it fully. If at all possible, it might be that the several national organizations might curtail their sessions so that a joint convention might be held at some strategic center. It is not an easy matter to settle. A decision could only be reached after adequate conference by the respective officers and boards.

"If the worst comes to the worst and all national conventions must be abandoned, it would seem highly desirable that the A.H.A. house of delegates meet with the board of trustees at least once annually. This is a contact body with the state and provincial associations and has a vital function in formulating national policies.

"As it is important to keep the A.H.A. constantly in mind as the one all-embracing organization, it might be possible under such circumstances to keep this national organization before the hospital field by having joint sessions in four or five major areas with the regional conference and with the portion of the A.H.A. in that area. It could be truly a joint session, with A.H.A. officers sharing responsibility with regional conference officers. National thinking could be maintained by the attendance at such meetings of the national officers and, of course, by the medium of the hospital journals and special publications."

BLACK SUGGESTS ALTERNATIVES

Pacific Coast people feel the need of conventions. Dr. B. W. Black of Oakland agrees that there are too many conventions and urges careful study of the two alternatives of either one great national convention for everybody or one large convention in the East, one perhaps in the South and possibly one in the West. "At no time have the American hospitals seemed more in need of close association at conventions."

Speaking for the smaller Pacific Coast hospitals, A. A. Aita of Upland, Calif., deplores the canceling of the western convention. "We are so far from the meeting place of the A.H.A. that many will not be able to attend; yet we need information and inspiration."

So far the only note of disagreement to the general idea has come from a distinguished source, Dr. Malcolm T. MacEachern, who states that the idea of a joint committee is not practicable or feasible and there is danger in too much displacement of present day routine "for this might gradually and insidiously undermine morale. The directing heads of the national associations are in close contact and can take care of the problem without another committee."

EXHIBITORS DISAGREE

The attitude of the manufacturers and dealers, of course, centers more upon the exhibit than upon the meetings themselves. Elmer H. Noelting, secretary-treasurer of the Hospital Industries Association, states that numerous exhibitors have suggested that his association do everything in its power to call off the A.H.A. convention in October because they have so little to sell. But he does not agree.

"I believe that at least one convention should be held per year for the general welfare and that the Catholic show and the A.H.A. show and all other hospital shows should be combined for the dissemination of any information that can be brought together for the welfare of the hospital industry as a whole."

Lawrence Davis of the Lewis Manufacturing Co., Bauer and Black, believes that action taken now "should result in a stronger, more aggressive, more hopeful national setup of hospital conventions that would endure well beyond the present emergency." Commenting on the suggested joint committee to work on this problem, he says:

"I believe such a board should be organized immediately. It should include, in addition to representatives of the leading hospital associations, one or more representatives of the Hospital Industries Association. A complete analysis of hospital populations should then be made; the scope of activity of state and sectional hospital associations as they now exist should be studied. The committee should undertake this assignment without fear or favor and develop a national setup of hospital associations that would serve the purposes of the whole hospital body and not organize to protect any present political or geographical setup.

"For some time I have felt that the strong sectional meeting offered much to the attending delegates. I refer to such associations as the Tri-State, Southeastern, Western, Midwestern, New England and Carolinas-Virginias. It seems to me that the A.H.A. and C.H.A., instead of being weakened by strong sectional associations, could be strengthened.

"It is unfortunate that both the national and the regional and state associations have to depend in such a large measure on income from exhibits. If some plan could be worked out by the joint committee whereby there would be six or eight strong sectional associations, full recognition should be given to the financial requirements of the less strong, less successful states. . . .

"If a committee is appointed, kid gloves will have to be removed. It can be done, but will it?"

F. J. Wilson of Wilson Rubber Company expresses, in general, similar thoughts.

ADVOCATE REGIONAL MEETINGS

The A.H.A., through its committee on regional assemblies under the chairmanship of Doctor MacEachern, has been gently urging the states to join in regional assemblies. In its report last year it noted six such assemblies covering 35 states, two possessions and one province.

Foster McGaw, president of the American Hospital Supply Corporation, offers an interesting proposal:

"There are too many meetings, even for peace times. But during war times, only five or six national hospital and medical meetings are justifiable. Unless meetings are cut down we will be obliged to cut out many exhibits as there isn't sufficient manpower to handle them all. Furthermore, we feel these extra demands on man power, expenses and transportation facilities are unpatriotic.

"Many associations count on these meetings for financial support, without which their program and services would suffer seriously. I would approve, for the duration only, that all commercial exhibits be discontinued. We would be willing to pay these associations one half the sum paid

in 1941. The associations would have no obligation to us during the period this arrangement was in operation. This sum would act as a gift toward their work and we would pay it as long as no commercial exhibits were held by them—but only during the war."

Will Ross states that hospital conventions are more necessary now than in normal times but adds that commercial exhibits need not be a part of such conventions. "With the flood of government instructions coming through and the constant changes resulting from the dislocations of war time, it is highly desirable that enough conventions be available to the administrator to give him an opportunity to maintain a true sense of direction.

"The commercial exhibit should, I believe, be dispensed with for the duration of the war. Little new material will be developed during the war although many temporary substitutes will, of course, be made.

"This raises a practical question, of course, because most conventions are, at least in part, financed by exhibits. This might be provided for by the medium of space in convention programs. This might not be as productive of revenue but conventions themselves need not be as costly if the exhibits are dispensed with. I believe the majority of regular exhibitors will gladly cooperate. The suggestion for a joint committee to establish policies for war-time conventions is extremely practical."

Fred B. Hovey, secretary of the American Surgical Trade Association, points out that the educational value of exhibits will be less during the war.

Howard F. Baer, president of A. S. Aloe Company, St. Louis, goes even further in condemning large exhibits at this time, saying that "it is not right or fair or patriotic to tie up the nation's freight space with exhibit material. I don't know how many tons of stuff have to be shipped back and forth from the A.H.A. meeting but the amount is considerable. The problem is not easy because the exhibit income of the A.H.A. is in the neighborhood of $40,000.

"Most of us would be willing to pay for the space and not exhibit. I say this, having discussed the problem with such men as Foster McGaw, Will Ross and Ed Johnson. The local exhibitors and those who are sporadic attendants, of course, would not have any special feeling of loyalty and would probably not go along. Even so, I feel that the A.H.A. could count on a great deal of income from the larger national houses which would also be better off because they would not have the expense of paying railroad fares or of maintaining representatives.

"Definitely, I feel that the small state and sectional meeting should not have exhibits. A joint committee from the various hospital associations and the H.I.A. should be set up to discuss this important problem."

Interestingly enough, no one suggested the use of a convention registration fee, such as finances the meetings of the Progressive Education Association, parent-teachers' associations and many others.

Share the Burden

With Your Department Heads

WILLIAM J. DONNELLY

ADMINISTRATOR, PRINCETON HOSPITAL, PRINCETON, N. J.

NO SINGLE factor is more conducive to good morale among employes than the knowledge that each department head has been given authority and is responsible for the efficient conduct of the department. It is essential that the board of trustees recognize this fact and grant the administrator complete authority to operate the hospital within the outline of policy previously determined by the board. Trustees have every right to expect a regular accounting of the administrator's stewardship and he, in turn, should receive through either informal conference or written report a review of the work done by the various departments.

"Too many cooks spoil the broth" is an axiom worth noting in examining the pitfalls besetting an administrator. He must cultivate and direct the interest of the trustees so that it becomes natural for them to seek information about the hospital and its work from and through him and not by independent investigation. He must, in his relations with department heads, work with them and through them and not by direct contact with an employe.

The small hospital administrator should be acquainted with the operation of all departments, but he should never personally discipline or direct the work of individuals in any department. The only exception to this practice would be the observation by the administrator of an infraction of the rules that endangered the welfare of the patients or staff. Then, of course, it is right and proper for him to act promptly. This does not mean that he is to remain aloof from the employes of the hospital. If he is to encourage the proper spirit, he should be congenial at all times.

Careful selection of department heads by the administrator plus the granting of remuneration commensurate with the duties imposed upon the department chief are prerequisites to a policy of decentralized authority and responsibility. Another essential preliminary is an outline of the duties and responsibilities of each department and its relation to other departments. Emphasis on the interdependency of every department is required if the various aspects of hospital service are to be integrated into a satisfactory whole.

The administrator must always be available to discuss with department heads problems that need his consideration. However, he should not expect to be consulted before every minor decision is made. Department heads, as do administrators, will make mistakes. When this happens, unless matters of principle are involved, the administrator should back up the decision of the department head, meanwhile explaining how the problem might have been solved to better advantage.

The test of a good executive is his ability to select capable assistants and his willingness to delegate authority and responsibility.

96 Bed Voluntary Hospital Serves Farthest

HAWAIIAN OUTPOST

ANNA G. WILLIAMS, R.N., and C. W. DICKEY

FORMER SUPERINTENDENT, G. N. WILCOX MEMORIAL HOSPITAL, LIHUE, KAUAI, T.H., AND ARCHITECT, HONOLULU, T.H., RESPECTIVELY

KAUAI, known as the "Garden Island" because of its luxuriant tropical growth and heavy rainfall, the most northern of the Hawaiian group, was the last of the five large islands to establish a modern general hospital. The G. N. Wilcox Memorial Hospital represents an expenditure of nearly half a million dollars, but at no expense to the community as it was constructed and equipped with funds provided by a charity trust created by the late George Norton Wilcox, a sugar planter of far vision, who long before his death established a fund to be used "to carry on or assist in any kind of public, charitable, educational or religious work, and for the aid and advancement of the public health and morals."

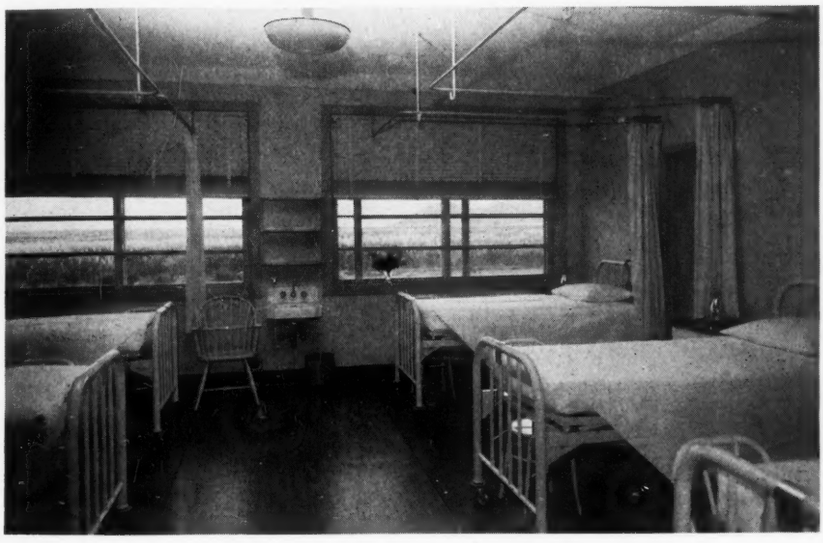
The Lihue Sugar Plantation gave the building site, which includes about 14 acres and is located less than half a mile from the village of Lihue. The plantation company reserved the privilege of erecting on the grounds a dispensary, adjacent to the main building, but to be operated separately and independently by the sugar plantation. However, dispensary service is being maintained in the company's old hospital building in Lihue.

The hospital's white buildings, with their green roofs, placed well back from the highway, fit harmoniously into their natural setting; on one side a valley opens a vista to the waters of the Pacific Ocean, while on the other sides mountain ranges and wooded slopes form the background for the cane fields.

The Lihue Sugar Plantation also provided a one and a half acre plot of ground on which to build a nurses' home and doctors' cottage. The location is ideal—directly across the road from the hospital. The nurses' home is surrounded by a charming old rock wall, coconut palms and tropical shrubs; a lovely lily pool has been laid in the back part of the grounds.

As is too often the case, Wilcox Memorial Hospital's administrator was not appointed until after the building plan was accepted and the contractor was on the job. Therefore, it was impossible to make cer-

Opposite Page, Top: Entrance to the G. N. Wilcox Memorial Hospital. The laboratory and x-ray department are located directly above the porte-cochere. Opposite Page, Bottom: Memorial lobby. Below, Top: View of the nurses' home and doctors' cottage across the road from the hospital. Below, Middle: One of the six bed wards. Furnishings and cubicle curtaining in these large wards are ivory; walls and venetian blinds are light green. The flooring is of mingled gray and black battleship linoleum. Two-panel sliding type windows provide ventilation no matter how strong the trade winds may be. Below, Bottom: Cottages are provided for hospital employes who live on the premises.



tain changes that would have been desirable, such as the exclusion of certain special equipment in the contract and alterations in the size and location of the labor and delivery rooms and the service rooms. However, changes, such as the location of the nursery, office rearrangements, placing of plumbing fixtures and doors, were effected, even though these resulted in exorbitant increased expense.

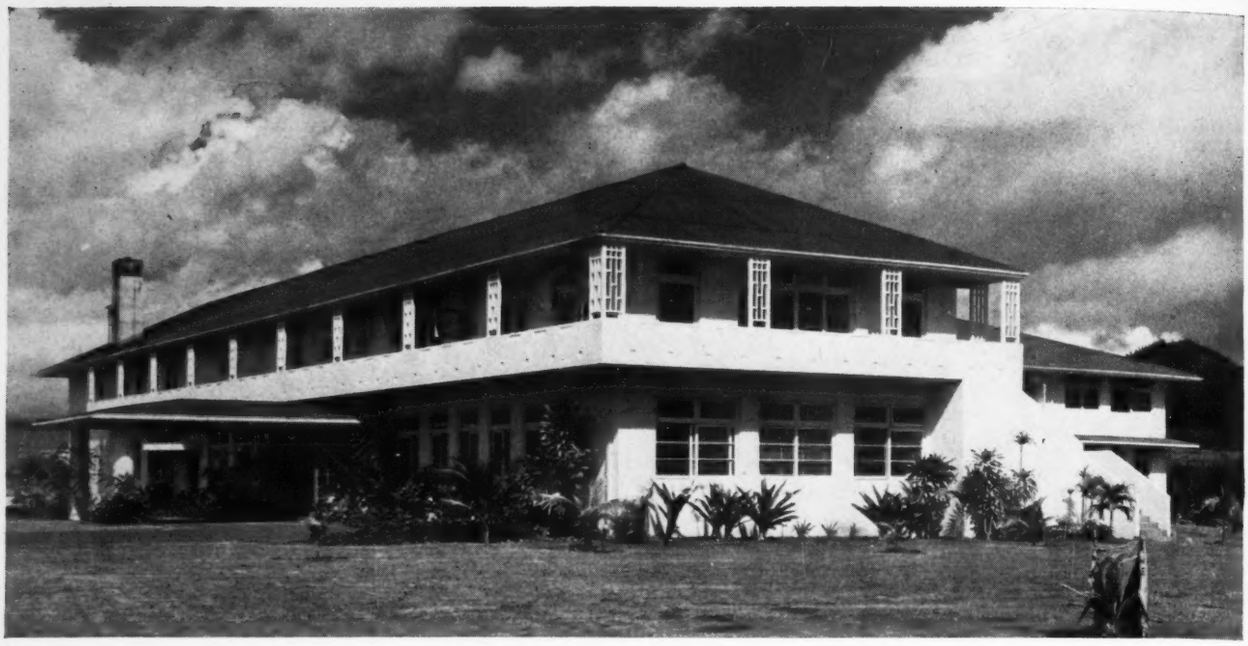
The institution is a private nonprofit general hospital, controlled by a board of nine trustees who hold full administrative power.

All qualified physicians, if members of the Kauai Medical Society and recommended by that body, are eligible for staff appointment on a yearly basis. The medical staff functions under its independent organization, the plans of which must, however, meet with the approval of the trustees. Its chief officer and secretary and three other members elected yearly serve as an executive committee. This committee acts as a liaison group between the staff and the administration of the hospital. The trustees, however, when acting on the appointments for the ensuing year, select and name seven physicians from whom the staff shall elect the three members to serve with their special officers on the executive committee.

A large percentage of the hospital service has been industrial, since three sugar plantations and one pineapple company refer all hospital work. Indigent service for the local and adjoining districts is likewise referred to the hospital, as are cases from the Veterans' Administration and the Crippled Children's Bureau from the territorial board of health. Private patient service is, of course, maintained.

Before the Wilcox Memorial Hospital was opened, practically all hospital work on Kauai was connected with the sugar plantations, except for two small private hospitals owned by physicians.

This hospital initiated a new type of hospital service and one that may be considered by some too costly for plantation cases, as all patient care is given by graduate nurses. The serv-



CONSTRUCTION DETAILS

GENERAL DATA: Two story building with part basement, reenforced concrete with corrugated asbestos roof over steel trusses and purlins. Building is modified T plan, accommodating 96 patients: 10 six bed wards, one four bed ward and five three bed wards; remaining 17 beds in private and semiprivate rooms. Connected with each ward is a service room with two toilets, shower stall and lavatory.

BASEMENT: Morgue and storage.

FIRST FLOOR: Right front wing—business offices, memorial lobby, record room, medical library, administrator's office, resident's office, drug room and emergency dressing room. Left front wing—dietary department, which includes employes' dining room. Back wing—medical and surgical male patients and communicable disease patients.

SECOND FLOOR: Right front wing—nine private rooms, two of which are de luxe, having a private bathroom and a small sitting room opening onto the balcony. Center front wing—x-ray department and laboratory. Left front wing—surgery and central supply service. Back wing—children's wards, medical and surgical wards for women, maternity department (accommodates 15 cases, with nursery, labor and delivery rooms). Each floor has spacious lanais (sun porches) with a view of the valley and the sea.

FLOORING: Concrete, except in surgery and service rooms, where floors are covered with quarry tile. Floors are chemically stained in dark green and brown tones and are waxed. Floors in ward corridors are covered with a mingled gray and black battleship linoleum with runners of this material on the floors of the wards.

WALLS: Smooth finish plaster over metal lath. Walls throughout are painted soft light green, with slightly darker green trim.

CEILINGS: Locally made acoustical plaster.

WINDOWS: Two-panel sliding type, allowing satisfactory ventilation even when trade winds become brisk. All windows are equipped with venetian blinds of the same color as the walls.

FURNISHINGS AND EQUIPMENT: With the exception of the de luxe private rooms, the memorial lobby and the medical library, all furnishings are of steel; private room furniture has harmonizing green finish and ward furniture has ivory finish. Cubicle curtaining in semiprivate rooms and small wards is of green twill. Yellow cubicle curtaining is used in the six bed wards. No draperies are used, since the scenery surrounding the hospital is far too beautiful to be obscured by hangings. Electrical outlets allow connection of all types of equipment at each bed.

ELEVATOR: Opens directly into kitchen.

SERVICE BUILDING: Steam plant, laundry, carpenter shop, garage and dietary department storeroom are housed in a separate building. The incinerator building also houses a reserve boiler.

EMPLOYES' COTTAGES: Three frame cottages for employes who live on the hospital premises are located in the valley. Each cottage has a recreation room. Single rooms are provided for employes holding responsible positions and for night service employes; others share double rooms. Adequate baths, service and laundry rooms are provided in the cottages.

NURSES' HOME: Four-court arrangement with every room opening onto a lanai. Constructed of hollow tile with plastered interior and exterior walls; cement floors; galvanized iron roof. Seventeen single and one double room for nurses; showers, toilets and lavatories between the rooms; one general bathroom with tub. Large living room with fireplace, small sitting room, dining room and kitchen. Storerooms, laundry and combination kitchenette and service room for nurses' use. Superintendent's apartment (living room, sun porch, bedroom, bath and kitchenette) is part of the nurses' home.

DOCTORS' COTTAGE: Accommodations similar to nurses' home; garage for cars of personnel.

ices of a resident physician, an anesthetist, a laboratory and x-ray technician and a dietitian are also provided.

That it is possible to provide skilled service at reasonable cost is being proved, we think, by the fact that the per diem cost of $5.79 for the first six months' period was lowered to $5.37 for the entire first year's period, with a per diem cost of $4.89 for the year 1940. This figure excludes baby care and also depreciation. The patient day average was decreased from 8.4 in 1939 to 7.5 in 1940. The 40 per cent occupancy of the first year was increased 25 per cent during 1940, which, no doubt, in part was the result of an influenza epidemic during October and November of that year.

With an island population of 35,833 persons, according to the 1940 census, and the total mileage around the island only from 75 to 80 miles, with excellent highways and ambulance service provided, it would seem that patient transportation and physicians' travel requirements should not present any special problem.

There are problems, however. But what new project escapes them? With the hospital an outright gift to the community and the inauguration of an entirely new type of service—not only in patient care, but for the physician, also, as he necessarily became part of an organized group instead of an independent worker—we feel that progress has been remarkably gratifying.

CUT DOWN *Supplies;* CUT OUT *Waste*

★ *Before looking for a substitute, see if you can do without. Each commodity that can possibly be eliminated without impairing service is an important victory in the war on waste*

JACOB GOODFRIEND
ADMINISTRATOR
JEWISH HOSPITAL, PHILADELPHIA

WASTEFULNESS is not a rare vice. It is shocking to note the number of persons on the hospital staff who are careless with the property of others. We find them in all parts of the institution, among the clerks, interns, nurses and the visiting staff.

The administrator who buys things first and tries them later and the executive who is too busy to ask for a demonstration of the equipment he is about to purchase and never bothers with samples are excellent illustrations of wastefulness in high places. Such persons are sure to be the not-too-proud possessors of hospital museums of unworkable gadgets.

The average conscientious hospital employe is irritated by and resentful of unnecessary waste and the thoughtless investment by the hospital in fads and fancies. On the other hand, personnel generally will follow in the footsteps of a prudent and economically wise executive. One sure lesson that this time of strife will teach is a knowledge of what we can get along without. The keen edge of economic scarcity will surely shear the frills from naïve purchasing procedures.

ADMINISTRATION

1. Cutting down on nonessential telephone calls will save the time of the caller, of the operator and, most important, of the person called. A circular recently distributed by a telephone company reads: "A short wait on the line saves telephone time. It's more courteous to the one you're calling and it cuts the cost of the call. When you place a call and then go away, you tie up lines and cause delay."

2. The petty cash account should be carefully supervised. Many items that do not belong there find their way into this account and not infrequently defeat the purpose for which the account was established. Satisfy yourself that the control of this account is still under the direction of the individual who was originally delegated to administer it and that the responsibility has not been assigned by him to a subordinate.

3. The collection system should be reviewed to determine whether it still functions as effectively as when it was installed. The percentage of bad accounts should be checked; it may point to careless collection methods or poor credit work. Has every effort been exerted in the collection of an account before it is "written off"? Are the social service reports of patients admitted to the hospital as complete and efficient as they used to be?

4. The backs of old printed forms can be utilized to a great extent by cutting them into sizes suitable for memorandums or for reprinting small forms.

5. Twine can be employed in the place of rubber bands.

6. When surfaced wood is exhausted, old crates and scrap wood can be used in the occupational therapy department.

PERSONNEL

1. The means by which an employe's interest in his work is aroused is unimportant; the suggestion box, the questionnaire or the conference may be adopted, but it is not possible to conduct a good hospital without the active cooperation and interest of each employe. When an idea is offered that cannot be adopted, a tactful explanation should be made so that the interest of the individual may be retained. He should be encouraged to try again. Many of the suggestions included in this article were submitted to me by staff members and personnel.

2. It is true that we cannot do much about labor turnover at this time. We cannot compete with industry and the government. Let us at least not compete with other hospitals by offering their employes higher wages to attract them. The other hospital might, in turn, offer them still more to keep them. Strange as it may seem, the hospital with an abnormally high wage scale is likely to be just as short of personnel as are others that pay less. They have as many discharges for intoxication, as many resignations for better jobs and as high a percentage of labor turnover as the others.

3. Now, more than ever, more frequent departmental conferences should be encouraged. They are stimulating to department heads; they will bring us closer to hospital problems. Department heads should be given an opportunity to air and share their troubles.

4. Do you utilize volunteer service to the fullest extent? Is this service well organized and is super-

vision adequate? Never in the history of hospitals have so many able and efficient persons considered it a privilege to serve. Moreover, they are willing to prepare themselves adequately for such services by taking courses made available to them both inside and outside the hospital. They can be used as nurses' aides, ward clerks, receptionists, typists, dispensary clerks, makers of surgical dressings, kindergarten teachers, librarians, record room clerks, occupational therapy assistants, canteen workers.

CLINICAL SERVICE

1. If witch hazel can be easily procured it can be utilized as a back rubbing lotion in the place of alcohol.

2. Formalin used for sterilization purposes can be filtered and used for the preservation of specimens. It can be recovered in the laboratory and used for morgue purposes.

3. Alcohol for arm dips can be filtered and used for minor surgical purposes. It can be refiltered and returned to the pharmacy for waste purposes.

4. Limited amounts of drugs should be poured in the solution basins for painting the skin. More can always be added if necessary.

5. Absorbent sponges can be substituted for 4 by 4 inch plain gauze dressings; 3 by 3 inch and 2 by 2 inch sizes are often found to be adequate; 4 by 8 inch gauze dressings can be substituted for large abdominal dressings.

6. The use of smaller abdominal dressings will cut down the consumption of adhesive plaster. Economy should be exercised in the use of the large sizes of adhesive.

7. Rubber gloves can be mended and used both in operating rooms and in the central surgical supply room. Silk, cellophane or some other material can be used for rubber dams and special rubber dam drains. Old rubber gloves have not proved satisfactory.

8. Tubed tension suture can be bought in bulk and sterilized repeatedly. If surgeons are made suture conscious, a great deal of material can be saved.

9. Costly avertin should be eliminated except for hyperthyroid and other selected cases, and paraldehyde, which can be purchased by the barrel, should be used.

10. The same kind of antiseptic should be used for all operations, if possible.

11. Sterile gowns can be eliminated from intravenous setups. Use of a second pair of sterile gloves in the delivery room should be avoided in normal cases.

12. The lightest possible dressings can be used in the surgical outpatient department on cases sent to the physical therapy department, since these dressings remain in place for only a short time and are then discarded. Towels can also be used for the purpose.

13. A skin antiseptic consisting of aqueous solution of 1.85 per cent solution of iodine and 2.2 per cent of potassium iodide has proved satisfactory.

14. Soap can be put in a basin and dipped out with sponges instead of pouring, especially for preparations of the vulva at delivery and for perineal operations. Antiseptic solutions may be spread on the skin with an atomizer rather than applied with gauze. There is a question, however, whether this procedure is economical, inasmuch as some of the spray would extend beyond the field and be applied to surrounding linen.

15. In the circumcision room, if visitors can be separated from the operating room proper by a glass and wood partition, contacts will be avoided and a saving will be effected in the number of sterile gowns required.

16. What can be done to reduce the number of unnecessary laboratory tests and x-ray examinations? We have found increased rates for these services to be an effective remedy. Such increases, however, might not be necessary if reasonable care were exercised and the abuse of these facilities were avoided.

NURSING SERVICE

1. Both sides of the history sheets in charts, including nurses' notes, should be used.

2. Newspaper can be used in place of parchment paper for specimen jars.

3. Linen sterilizing covers that are laundered frequently can be used several times before laundering. Parchment paper has been found effective and satisfactory for this purpose in a number of hospitals.

4. To save muslin bandage, bed posts can be fitted with lugs, or leather straps can be used to tie side gates in place.

5. Pads made from old sheets and pillow cases and filled with a layer of old bath towels can be substituted for drainage pads for incontinent patients.

6. Straps made of muslin can be used to tie an arm to an arm board while giving intravenous treatments. This procedure will save gauze bandage.

ENGINEERING DEPARTMENT

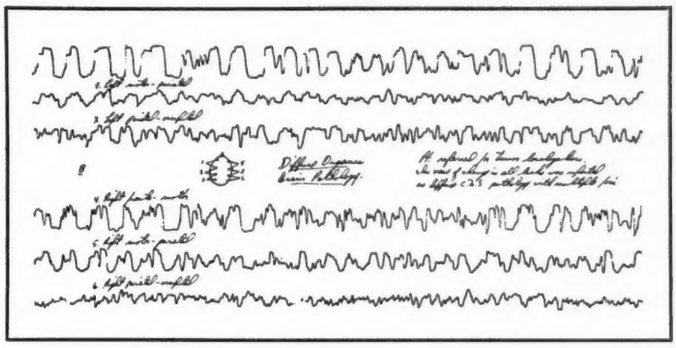
1. A system for the care and preservation of machinery and equipment to ensure longer life should be inaugurated as a war-time program. The wealth of information on this subject now obtainable without cost will stand us in good stead, even in peace time.

2. The scarcity of good mechanics for hospital jobs makes the task of proper care and preservation of motors and machines doubly difficult. If, for example, the periodic lubrication of the extractors in the laundry is neglected, the bearings will burn out in a short time; a costly repair job and the temporary loss of the machine will follow.

3. In such departments as the laundry, kitchen, x-ray and physical therapy, where many machines are in constant use, it is a good plan for the engineer or his assistant to make daily inspections of the equipment and to arrange promptly for necessary repairs or replacements. The requisition-for-repair system for such work, which most hospitals have adopted, has proved inadequate because many needed repairs, which a dietitian or laundry man would not detect, can be made before the apparatus breaks down or before someone is hurt.

4. A survey of electric lighting facilities for emergency purposes should be made. The size of electric bulbs in various locations and departments should be checked with a view to using smaller bulbs where possible, taking into consideration, of course, the type of work performed and any other factors involved.

Many such economies will suggest themselves when and if we make rounds regularly and look for them.



ELECTRO-ENCEPHALOGRAPH

is important diagnostic aid

JACK R. EWALT, M.D.
ASSOCIATE PROFESSOR OF NEUROPSYCHIATRY
UNIVERSITY OF TEXAS, GALVESTON

THE use of the electro-encephalograph in clinical practice has increased rapidly in the past few years, largely through the researches of W. G. Lennox, Frederick Gibbs, H. Jasper, P. A. and H. Davis and other workers in this field.

These workers have taken the pioneer researches of Hans Berger and through careful correlation of clinical material and electro-encephalographic patterns have developed certain criteria that make the method useful in clinical work.

It must be emphasized that more refinement of interpretative methods is needed and that further carefully coordinated clinical and laboratory studies are required to expand the usefulness of this type of study, but this should not postpone the utilization of the considerable fund of factual information now available through the use of this apparatus.

The method has been widely used in the study of convulsive disorders and may be said to offer more information in these states than any other single test or examination. Lennox and Gibbs have worked extensively and carefully in this group of disorders and have placed the diagnosis upon a sound, objective and physiologic basis.

The use of the electro-encephalogram not only affords a rapid method of diagnosis but also offers a valuable guide as to the efficacy of a particular type of treatment in controlling the convulsions.

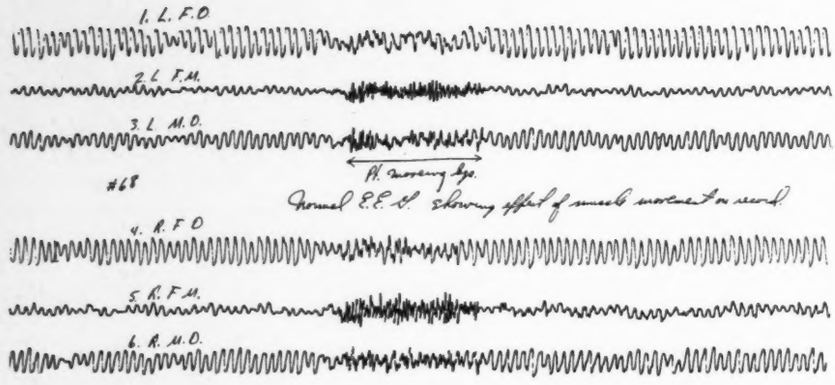
A record showing large, irregular fluctuations in the rhythmical electric activity of the cortex is illustrated in the accompanying photographs from records of patients suffering from idiopathic epilepsy. Large waves of this type are found in practically all patients suffering from epilepsy and their presence confirms a clinical diagnosis of a convulsive disorder. When the patient is placed on effective anticonvulsant medication the frequency and severity of attacks are greatly reduced or altogether avoided and the clinical improvement is reflected by a decrease in the number of abnormal waves found in the electro-encephalograph record.

The use of this method avoids the prolonged delay incident to observing the patient until he has a seizure, which, prior to the development of this method, was necessary to establish the diagnosis. Repeated tracings taken after anticonvulsant therapy is started reveal a return toward a normal record in those patients receiving medication in quantities large enough to control their convulsions. This method of study materially shortens the period of observation necessary to determine the optimum dosage of anticonvulsant drug in each individual. Schwab, Greenwald and Sargant have developed a refined method of studying this aspect of the problem.

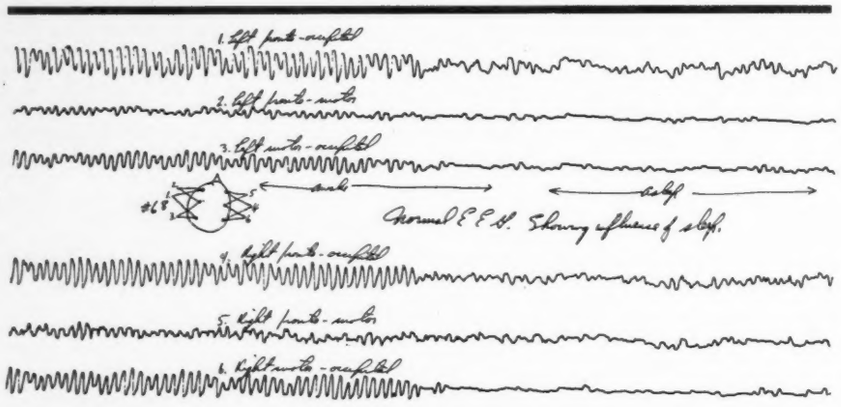
A further use of the electro-encephalograph that has been insufficiently emphasized is in study of psychic equivalent states in epilepsy. Some patients suffering from this form of the disorder present symptoms resembling functional psychoses or neuroses and the first clue to the nature of their disorder is offered by the electro-encephalographic tracing.

The second great field of usefulness is in the localization of brain tumors involving the cerebral cortex. Clinical localization of tumors of the cerebral cortex, especially those involving the frontal lobes, is difficult and at times impossible in the early stage of the growth. In these cases carefully plotted electro-encephalograms, according to the method of Walter, will often localize the area involved. The method is not yet sufficiently developed to enable the operator to determine what type of lesion is present, but the localization of a focus of disturbed cortical physiology makes further exploration by air injection or by craniotomy a more rational procedure.

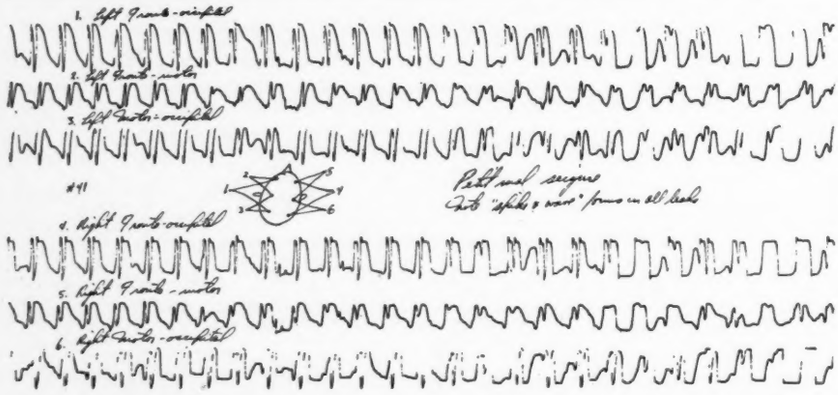
Electro-encephalograms will also give valuable evidence as to the physiologic state of the cortex in



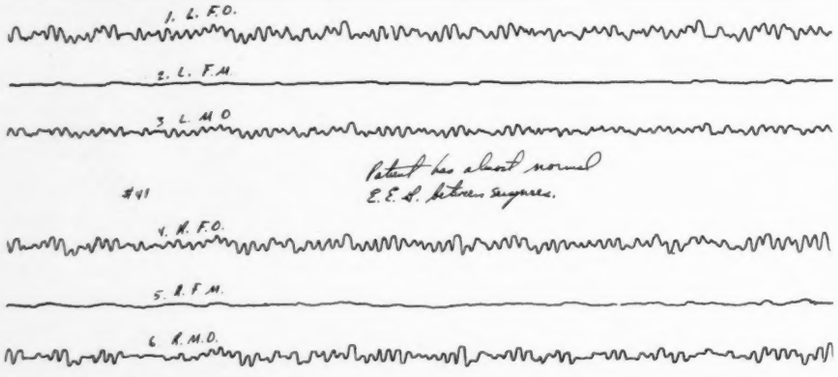
Section of normal record showing 10 per second or "alpha waves" of 40 micro volt amplitude. Record shows effect of voluntary motor acts on the electro-encephalogram.



Normal tracing showing the influence of sleep on the E.E.G. record. This patient was suffering from a psychoneurosis, the principal manifestation of which was convulsions.



Portion of E.E.G. tracing made during a petit mal attack of idiopathic epilepsy. The presence of spike and wave forms confirms a clinical diagnosis of a convulsive disorder.



Section of E.E.G. record between seizures from the patient whose tracing during attack is shown above. This interval record shows normal 10 per second waves.

head injury cases and so-called post-traumatic encephalopathies. Williams has reported use of the apparatus in following the progress of a group of these patients and believes that there is a rough correlation between the severity of symptoms and the amount of abnormality manifest in the electro-encephalogram. Further experimental work is necessary in this group of cases before the clinical conclusions are as reliable as in the epilepsies, but the presence of fairly constant large, slow, irregular waves in the electro-encephalograph record should make one wary of a diagnosis of posttraumatic neurosis. On the other hand, a normal cortical tracing should stimulate the examiner to make further investigation into the possibilities of a neurotic reaction or perhaps a feigned disorder.

The instrumentation of electro-encephalography is an important phase of the problem. The present apparatus is a marked improvement over that originally utilized by Berger; in the last two years the equipment has become fairly well standardized.

At present the most satisfactory equipment is a vacuum tube amplifier which amplifies about 10,000,000 times. Various types of recording devices are used, but the most satisfactory ones record in ink on paper, the pens being driven by electromagnets and the paper tape being pulled through the pens at a constant rate of speed. I have had personal experience with such an apparatus and have found it quite satisfactory and dependable in operation.

The future will undoubtedly bring mechanical improvements in this field just as we anticipate further changes in electrocardiograph and x-ray apparatus, but the properly built machines now available are sufficiently dependable for daily use in the busy hospital or clinic.

The research possibilities of this apparatus are many and further standardization of the technic is essential, but at present the method has enough practical uses to make it a necessary part of the equipment of any hospital or clinic that pretends to do complete diagnostic studies on patients suffering from the various disorders of the central nervous system.

If You Want Better Service

Build Up Morale

When sharing experiences through group conferences develops an understanding of one another's problems and stimulates cooperation—that's good morale

SALLY JOHNSON, R.N.
SUPERINTENDENT OF NURSES
MASSACHUSETTS GENERAL HOSPITAL, BOSTON

DO NOT the times in which we are working make it necessary for us to revaluate the word "adequate" and the word "quality"? Does anyone think for a moment that we can continue to give patients the amount or the quality of nursing care we could formerly give? Does anyone think that seven nurses can do the work of 12? Does anyone think that a bath given by an immature and socially limited ward helper will do for the patient what a bath given by an intelligent, well-prepared nurse will do? A bath given by a good nurse does something for the patient besides getting him clean. The question, then, resolves itself into: "What can we do to keep our nursing care up to the highest possible standards?"

Every man and woman from the president of the board of trustees to the cleaning woman will agree that the prime factor in keeping up as high a quality of service as possible is that of maintaining high morale within the institution. Furthermore, every person from the president of the board of trustees to the cleaning woman must contribute to that morale. There must be mutual understanding, appreciation, sympathy, courage and helpfulness. These are best maintained through the conference method. Conferences should be held with every group, including the student nurses.

The most important contribution to morale is mutual understanding. Everyone concerned should know why there is a shortage of hospital workers and nurses. How many of them can offer an explanation other than that "workers have gone into the defense industries and nurses have gone into the Army camps"? When only about 28 nurses have gone into the Army from a group that supplies an institution with a daily average of 556 graduate nurses, this cannot be the only cause of the shortage.

There must be understanding not only within a given department but also among the various departments, *i.e.,* dietetic, occupational therapy, social service, housekeeping and maintenance, and, most important of all, the medical staff, from the chief of staff to the youngest house officer.

The principal interpreter to the medical staff will be the director of the hospital. He must be provided with specific data which he can present at the meetings of the staff. For example, he must be able to report, "Today in the general hospital we are minus 16 graduate staff nurses, nine orderlies, eight men students, 10 ward helpers and nine student nurses who have been lent to another division—a total of 52."

The most commonly proposed answer to all the employment difficulties is "shorter hours and higher pay." While it is true that the nonprofit institution cannot compete with industry as to hours and pay, this answer cannot be dismissed. Hours of work and rate of pay must be made reasonable and fair. When this has been accomplished and shortage of workers still persists, we must look into other possible solutions.

Each problem as it comes up should be given separate consideration. When it is presented by one of your workers, listen sympathetically and ask him to suggest a remedy. If it is a good one, help him to apply it. Make every effort to find a cure for the ills. Discouragement should not be added to discouragement. Don't say, "All this is due to the times we are living in," and close the interview there. We cannot change the times but we can make them more endurable.

One of the quickest and easiest methods of finding ways to improve conditions is to learn from one another, by pooling experiences. Experiences can be shared by telephone, letter, questionnaire, conference, reading the literature, visiting other institutions and attending conventions. Another satisfactory method is to consult the most intelligent, honest and cooperative members of every group of workers and listen to their viewpoints.

Supplementary workers are becoming more important in these days of personnel shortage. First, there are the ward secretaries, who should be used more extensively. They do all paper work that can safely be done by a lay person; they answer telephones and direct the numberless visitors who come to the ward. The majority of these workers can use a typewriter but only a few can

Adapted from a paper presented at the meeting of the American College of Surgeons, Boston, Nov. 3, 1941.

take dictation. Ward secretaries are women of refinement and intelligence, many of whom have a small private income which, when supplemented by a small salary, enables them to live on an acceptable level. They are a stable group of employes and their length of service is measured in years, not months. Some of these ward secretaries, those known as semivolunteers, practically donate their services, but transportation, lunches, smocks and their laundry are paid for by an allowance of $1 a day. These semivolunteers are recruited from persons who do not need to earn but who wish occupation, those who are preparing to be medical secretaries and those who hope to be promoted.

Then there are the Red Cross nurses' aides. The institution with which I am connected has participated in the preparation of these aides for six years. Five hundred and eighty-three have been prepared. This number includes 97 business and professional women who have taken their classes in the evening and have done their practice on week ends. In June 1942 the daily average number of aides in the hospital was 10; 124 were in active service and their total service time amounted to 3059 hours.

Another group of workers is called hospital aides, with which the Household Nursing Association in Boston is experimenting. The first month of the two months' course taken by these aides is spent in the classroom of the association and the second month is spent in practice on the wards of affiliated hospitals in which they are expected to work for at least six months for a wage agreed to by the hospitals. Fourteen persons completed the first course. The association is giving organized preparation to hospital ward helpers, which is almost impossible for the hospital personnel to give to a changing group.

Everyone knows that these supplementary groups are lifesavers, but the hospital must be interpreted to them and they must be supervised. In the majority of situations, additional personnel must be obtained for this supervision. Without adequate supervision of the supplementary workers, there is danger of lowering the hospital's standard of patient care.

A list of other contributions to more adequate care and higher quality of service may include putting all ward equipment in good order, adding new equipment, rescheduling hours on duty, simplifying nursing procedures and changing the sequence of procedures taught in the preliminary course. The new equipment added may well include more expensive items, such as blood pressure machines and photostatic machines. Suppose, for a moment, that during the last five months the census of personnel has been below normal to the extent of 10 staff nurses, 6 orderlies, 6 ward helpers, 3 ward maids and 3 porters. This modest shortage has lowered the hospital expenditure by nearly $13,000. That sum will contribute toward paying for additional personnel and additional equipment. Certainly, those employes who stay by the institution, working when overtired and taking criticism they do not deserve, should be given all possible help.

Supplementary Report on

War-Time Shortages

WE reported last month on a study of the effect on hospitals of war-time shortages of equipment and supplies. At the time that article went to press a total of 96 replies had been received. Now (August 11) a total of 281 replies is in. These letters have been divided into the same two groups—group 1, including those hospitals which have not yet experienced shortages serious enough to interfere with proper care of patients, and group 2, consisting of hospitals in which this interference has already appeared. In group 1 there are 141 hospitals; in group 2, 140 hospitals.

It should be emphasized, however, that a strict interpretation was placed on the answers. No matter how much delay or inconvenience was caused to the hospital officers, the letter was not put in group 2 unless the administrator stated that the lack of supplies and equipment was already interfering with the care of patients.

Copies of all letters in group 2 have been forwarded to appropriate officials in Washington in the hope that they may be able to help some of the hospitals that are in greatest difficulties. Also, it is expected that through a perusal of these letters they will gain an over-all perspective of the effect of present restrictions.

Two important facts stand out from a careful reading of all the replies. First is a splendid spirit of willingness by hospitals to do everything they possibly can to cooperate in the nation's welfare. Time and again administrators state that they have been seriously inconvenienced but are carrying on to the best of their ability and do not expect to have easy going. Most of them agree wholeheartedly that war now comes first.

The second important conclusion is that in many instances the full effect of the war restrictions has not yet been felt by hospitals. For many products there have been, until recently, large inventories in the hands of manufacturers and dealers. Although hospitals often could not get as much as they wished they usually received enough to get by. Even that period, however, will soon be over for many classes of items. Already the restrictions are beginning to hurt so far as sterilizers, centrifuges, electrical equipment and certain other products are concerned. Unless some of the present rules are relaxed somewhat, shortages will soon bite even deeper. The war demands are daily becoming more imperative — and rightly so.

Finally, it should be pointed out that many hospitals have felt the need of having someone in W.P.B. who is thoroughly familiar with the needs and methods of operation of civilan hosptals. This need has now been met by the appointment of Everett W. Jones to handle all hospital applications. While he can't work miracles, at least he can assure hospitals that their requests have been considered by one who is thoroughly familiar with present-day civilian hospital work.

Social Medicine Wins Support

FROM S. R. SPELLER, LL.B., EDITOR, THE HOSPITAL

London, England
July 20, 1942

DEAR Colleagues in America:

As I write my monthly letter to America it has just been announced that the Nuffield Provincial Hospitals Trust is cooperating in the foundation of an Institute of Social Medicine in the University of Oxford, the trust agreeing to contribute £10,000 a year for ten years in the first instance for the creation of a university professorship and for the foundation of the institute in which the professor will work.

The purposes of the institute are defined as follows: "(a) to investigate the influence of social, genetic, environmental and domestic factors on the incidence of human disease and disability; (b) to seek and promote measures, other than those usually employed in the practice of remedial medicine, for the protection of the individual and of the community against such forces as interfere with the full development and maintenance of man's mental and physical capacity; (c) if required by the university to do so, to make provision in the institute for the instruction in social medicine of students and practitioners of medicine approved by the board of the faculty of medicine in the University of Oxford."

There will be an administrative committee for the institute on which the trust will be directly represented by six members. In this way, cooperation will be furthered between the institute and other research institutions established elsewhere by the trust.

The foundation of this institute serves to place timely emphasis on the importance of preventive medicine and the fact that it is being sponsored by the Nuffield Provincial Hospitals Trust leads one to hope that, in time, a close liaison will be established with hospitals throughout the country and that the hospitals may appreciate more and more the value of preventive medicine and may take a more active part in its development.

Undoubtedly, if progress in preventive medicine is to be maintained, more time and money must be devoted to it, but neither money nor medical staff should be diverted from the curative work at the hospitals; we are glad that the trust has led the way in finding new money and sponsoring a fresh approach to this basic problem of human living.

Another interesting but less exciting piece of news this month is the decision of the Court of Appeal a few days ago in the case of Gold *v.* Essex County Council, in which the plaintiff, an infant, claimed from the defendants, Essex County Council, damages for injuries sustained by her when a patient in Oldchurch County Hospital owing to the alleged negligence of the defendants, their servants or agents.

Ruth Gold was admitted to the hospital for treatment for warts on the face. A staff doctor sent her to the radiology department with written instructions as to treatment. The radiographer, *i.e* a technician skilled in administering of x-ray treatment, but not a medical man, gave her the prescribed treatment but failed to protect the child's face during treatment in the proper manner; as a result she developed ulcers which caused permanent disfigurement.

Up to the present time, although there have been differences of opinion amongst lawyers, the generally accepted view on the basis of the decision in Hillyer *v.* St. Bartholomew's Hospital (1909) has been that, if a hospital engages duly qualified medical men, nurses, radiographers and similar technicians and has no knowledge of their habitual negligence or incompetence, it is not liable for any mistakes that they may make in the carrying out of their professional or technical duties. However, on the basis of another case, Marshall *v.* Lindsay County Council (1937) A.C.97, there has been a suggestion that the hospital is liable for negligence or incompetence in carrying out administrative duties, the borderline dividing the two types of duties being rather obscure.

On the basis of the Hillyer case, the trial court felt constrained to give judgment for the defendants on the ground that the radiographer was a duly qualified medical technician performing professional duties over which the hospital had no control.

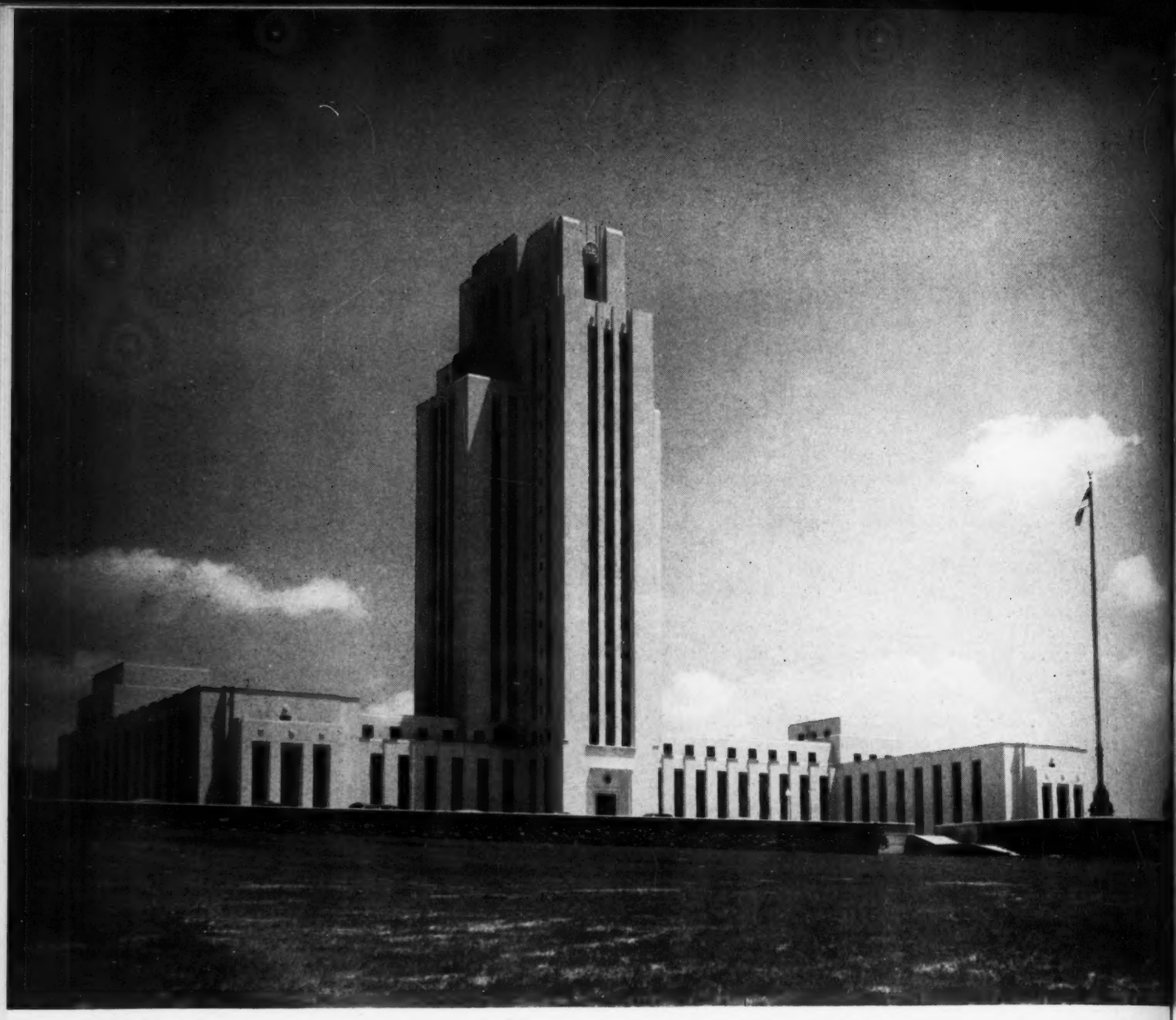
In the Court of Appeal, the Master of the Rolls (Lord Greene) and Lords Justices MacKinnon and Goddard reversed the judgment given in the court of first instance and awarded the plaintiff £300 damages against the hospital authority. The Court of Appeal distinguished this case from Hillyer *v.* St. Bartholomew's Hospital, which concerned what took place in the operating theater under direct personal control of the surgeon. There was nothing in that judgment to support the view that the hospital authorities were not liable for the negligent acts of nurses in the performance of their general duties of a purely administrative or domestic nature, such as giving a patient his meals. The true ground on which the hospital escaped liability for the act of a nurse was not that she was not acting as a servant of the hospital but that she was not guilty of negligence if she carried out the orders of the surgeon or the physician.

There was, said the Master of the Rolls, no authority for Lord Justice Kennedy's proposition in the Hillyer case that the only liability of a hospital was to see that a patient was treated only by experts of whose competence the hospital had taken reasonable care to assure itself and that those experts should be provided with p r o p e r apparatus.

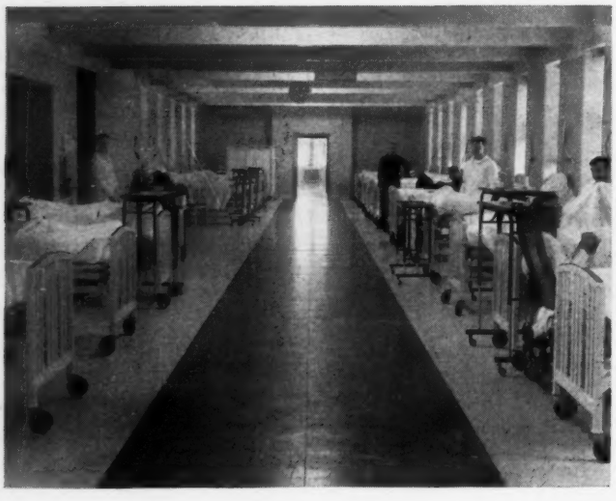
It seems, therefore, that the hospital does undertake toward the patient the duty of nursing him, as distinct from the lesser obligation of providing a skillful nurse. The obligation assumed by the hospital was to treat the patient by the hands of the radiographer or nurse with the apparatus provided. Consequently, the hospital is liable for the negligence of the radiographer.

Leave to appeal to the House of Lords was given and it is hoped, therefore, that the liability of hospitals for negligence may thus be finally settled.

On practical g r o u n d s, speaking purely as an individual and not as representing the views of hospital administrators or anyone else, I should like to see the hospital made fully responsible for the negligence or incompetence of its staff in the same way that a ship owner is made responsible for the negligence of the captain of the ship, although not able to exercise control over him. It is quite easy for a large institution, such as a hospital, to obtain insurance against such third party risks so that the drain on public or charitable funds need not be excessive in any year. But, on the other hand, the patient, particularly the poor patient, who is the victim of negligence, especially of a nurse or other junior member of the hospital staff, is left without any worth-while financial remedy unless he is allowed to claim against the institution.

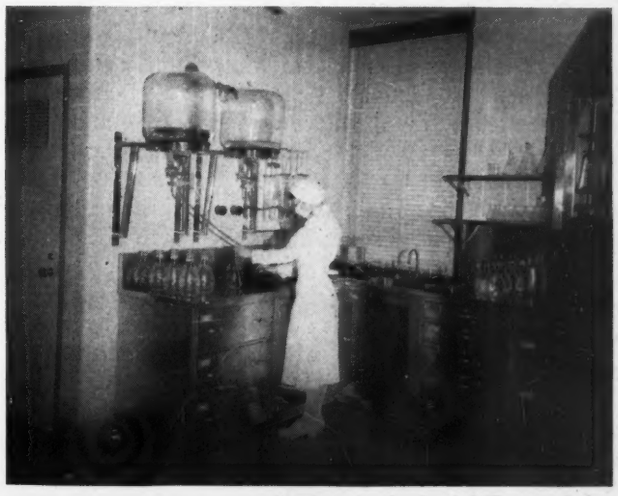


Naval Medicine Centers Here



★ *Located near Bethesda, Md., this $4,360,000 Naval Medical Center houses a hospital, a research institute and postgraduate schools for physicians, dentists and hospital corpsmen. Equipment for the hospital was purchased on the basis of Captain Lucius Johnson's report after visiting 30 leading civilian hospitals*

OPPOSITE PAGE: (Top) The new National Naval Medical Center site comprises 200 acres with a frontage of about half a mile. (Lower Left) One of the twelve 30 bed wards for sailors; the tower provides accommodations for 150 officers. (Lower Right) A well-equipped kitchen serves sailors and officers when they become patients in the Medical Center. **BELOW:** (Upper Left) Modern x-ray units are provided in the dental school incorporated in the Naval Medical Center. (Upper Right) A Navy nurse preparing sterile water in the sterilization section of the surgical department. (Lower) Main lecture room and meeting room serves also as a motion picture theater.



Out-Patients COME BACK

MARJORIE MYERS DOUGLAS

MEDICAL SOCIAL WORKER
GILLETTE STATE HOSPITAL FOR CHILDREN, MINNEAPOLIS

THE importance of regular check-up examinations for out-patients of an orthopedic children's hospital cannot be overstated. To the orthopedic surgeons periodic examinations are fundamental for evaluation of results in individual cases and for analysis of treatment and technics based on large numbers of records.

From a financial point of view this system of observation at intervals prescribed by the doctor may be regarded as a low-rate insurance of an investment that is often large when repeated operations, lengthy hospitalization or expensive orthopedic appliances are involved. In a tax-supported institution the public has a right to see that this safeguard is carried out; doctors who give or practically give their time should expect such an opportunity to watch and protect their accomplishments.

Obviously, the patients themselves gain the most from regular attendance at out-patient departments. However, especially in a public institution, such as Gillette State Hospital for Children, the Minnesota institution for treatment of crippled children up to 21 years of age, patients are likely to fail to take full advantage of this opportunity even with the utmost encouragement unless there is provision for some check on their failure to keep appointments and for help with specific problems preventing their return.

It is hardly surprising that when a medical social worker was added to the staff of this hospital in February 1937 through the agency of the Division of Services to Crippled Children (now known as the Bureau for Crippled Children), this problem was found by the worker and the administration to be the logical starting point.

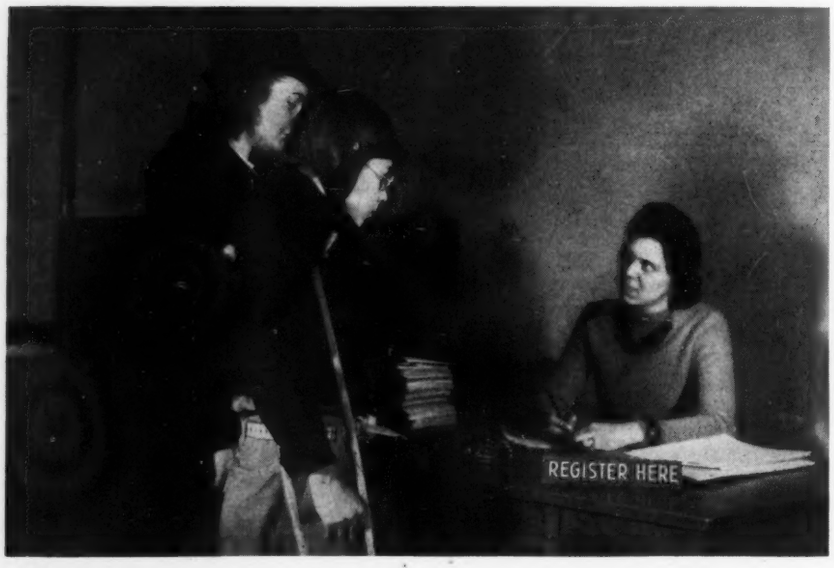
A medical stenographer was provided by the state agency and the hospital furnished office space and equipment. The 250 bed hospital had an out-patient file of more than 3000. A preliminary survey of 1070 of the charts of these patients was undertaken with the enthusiastic cooperation of the superintendent. Invaluable assistance in interpretation of medical findings and indications for treatment were given by the six staff doctors.

Study of the charts proved that: (1) nearly half, or 515, patients did not need to return to the clinic because they were more than 21 years of age or were apparently cured and had been advised to report back only if new symptoms appeared; (2) of the remaining number, 140 patients should have reported as long as from 5 to 15 years before; (3) 215 should have reported in the last one to five years, and (4) only 200 were keeping their appointments promptly or were less than one year overdue.

To the patients in the second category, letters (some form, some personal) were sent asking about their present condition, whether treatment had been obtained elsewhere and, if not, if they wished to return to the clinic. Return postal cards were printed with approximately the same queries for patients in group 3, but an appointment for any Thursday clinic in a specified month was given. This method was used for the entire group of 3000 patients.

A file of 3 by 5 inch cards was set up that included identifying data for all patients with future appointments. These cards are filed alphabetically by months. After the weekly clinics the cards of patients reporting are moved to the month specified by the doctors as the time of the next check-up examinations or hospitalizations.

By correspondence, we were able to obtain the return of many of these patients to the out-patient department. Many, however, had moved to new addresses and were finally found through writing to persons mentioned in old hospital correspondence; through determined checking with the post offices, the city directories and social agency registries, and by home visiting. Outside of the urban area, the six field nurses and physical therapists of the Bureau for Crippled Children, county, school and special nurses and welfare workers made



A patient registering for treatment in the hospital's out-patient department where the new follow-up service is a success.

countless visits at our request to locate the patients and impress them with the importance of continued care.

Inability to provide transportation to the out-patient department was a problem that was solved with relative ease through the kindness of the railroad companies and private welfare agencies. Fear, ignorance, inertia and preference for the easy promises of quacks were problems that had to be met with patient and sympathetic explanation and appreciation of the attitudes of the patient and his family and study of their emotional interrelationships.

One of our staff doctors met queries of farming families as to how long a patient would need to be in the hospital with the question, "How long does it take corn to grow?" Parents who objected to a child's having to wear an "uncomfortable leather jacket" to help in the treatment of a crooked back were reminded of their use of props or braces to make a crooked tree grow straight. This doctor put his finger on the secret of explaining not in mysterious and frightening medical language but in terms of the patient's own experience.

This philosophy later led to the practice of the medical social worker's interviewing parents of each new hospital admission to gain a working knowledge of their particular social situation and attitudes toward the child and his illness and writing up this information for the use of the doctor and hospital staff. It also gave her an opportunity in a private and more leisurely interview to answer questions and give general interpretation of the implications of the patient's condition and necessary treatment. This system has the inestimable value of attempting to gain the parents' and patient's understanding cooperation at the beginning.

Nearly a year was needed to establish the follow-up system although many of the medical social problems uncovered during the process remained under treatment for a long time. Printed reminders or personal letters are sent giving a new appointment if a patient becomes as much as three months overdue. This necessitates approximately 75 to 150 communications a month. The system has operated smoothly, however, and the field workers take over when correspondence has been ineffective.

When this plan of medical follow-up had been in use for two years a second study was made of 1070 charts selected at random. The comparative results of the two studies are shown below:

Studies Made:	1937	1939
Return only "if trouble"	515	319
5 to 15 years overdue	140	8
1 to 5 years overdue	215	118
Keeping appointments promptly	200	625

The smaller 1939 figure for patients to "return if trouble" is explained by the fact that the administration in 1937-38 sorted some "cured" and over-age cases, patients who had no follow-up date, out of the active file. A small number of cases went into this group, when the doctor was satisfied from a patient's letter or a report of a physical therapist's examination of the patient at his home that further treatment was not necessary.

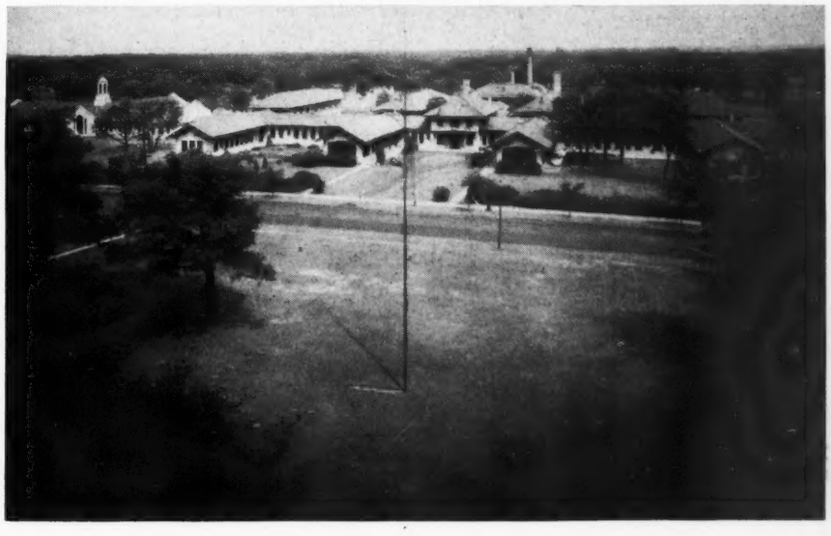
If we subtract this group of patients, we find a total of 751 remaining in the 1939 study and 555 in the 1937 study; this is roughly 1-1/3 times as many. If the 1937 figures are multiplied to get a comparable base we have the following schedule:

Studies Made:	1937	1939
5 to 15 years overdue	189	8
1 to 5 years overdue	290	118
Keeping appointments promptly	270	625

In 1937, therefore, only one third of the patients supposedly under treatment were keeping their appointments promptly but through follow-up efforts the proportion was brought to five sixths in 1939. In 1937 nearly one fourth of the patients were from five to fifteen years overdue; actually, they would never have returned. In 1939 this group was only 1/100 of the total and several have since been brought under observation. Of the 118 who are from one to five years overdue, many have already reported once since 1937 and are again overdue.

Of the patients who had stayed away as long as three years, none in the group studied returned voluntarily. There was some question as to the wisdom of spending large amounts of time to persuade these patients to return. Therefore, a check was made of 101 patients of the sample of 1070 whose return to clinic was obtained after at least a three year absence. Of these, only 16 were advised that they need not report again. Forty-one were to remain under observation or to have treatment in the out-patient department and 33 were given hospital care (25 of these operative care); for 11 more, hospital admission was advised at once or within a short time.

The results of this study show clearly the advantages of an accurate system of medical follow-up. If such a plan is administered or supervised by a medical social worker, it makes a satisfactory basis from which the work of her department can develop and contribute more and more to the medical improvement and social adjustment of the patients.



Overhead view of the Gillette State Hospital for Children where Minnesota's crippled children receive treatment.

YOU *CAN* GET BLOOD FROM TURNIPS

RAY E. BROWN
ADMINISTRATOR, SHELBY HOSPITAL
SHELBY, N. C.

DURING the last twelve months we cut our charity load by 31 per cent. Like most hospitals serving an industrial and agricultural area, Shelby Hospital was confronted with a large group of patients with an income and a way of living not conducive to saving for the rainy day. Patients, perhaps, intended to pay their hospital bills if they ever got far enough ahead to pay—a way of thinking that cleared their own consciences but would never clear many bills. Their income, while small, was steady and sufficient to permit small payments, yet they seemed unable to keep promises to make such payments.

A close study of our procedures showed that our admission clerk was doing a good job. All the information was at hand. The problem was to use that information to force savings for the rainy day that had already come.

To force a person to save meant to obtain a portion of his money before he had an opportunity to spend it, or going to the source of his income.

COLLECT FROM INCOME SOURCE

The largest increase in collections came from pay roll deductions. If, upon admission, it appeared that the patient was not able to pay but had a regular income sufficient to pay a small sum weekly he was asked to sign a pay roll deduction order. The amount of the deduction was set by a study of the patient's weekly wage, size of family and other factors bearing on his income and expenses, and care was taken to see that the amount was not too large. Not only is this important from a social side as concerns the living standard of the worker but it is important to convince the worker that the hospital has his welfare at heart and does not want to overburden him.

The greatest amount of effort expended in our collecting work is that of constantly contacting the employers, who are the pivot points of low income collections. If a hospital administrator can interest an employer to such an extent that he considers it a duty to help collect from his employes there is no doubt that an interest in the total hospital problem has been kindled. No employer is too small to escape our program. If he employs only one person and that person owes the hospital, we present our case.

For years our hospital had been taking a licking on its emergency work from wrecks and fights. Our means of forcing payment for this type of work was to sell the court on our problem. Now, we turn our bills over to the court and the sentence generally ends with "and payment to the Shelby Hospital of all bills incurred in said hospital for treatment of defendant."

Tenant farmers not only are a thorn in the side of the social workers with reform in their bosoms but are an enigma to the man who must furnish them necessary hospitalization and has no hope of collecting for it. We have solved this problem in part through the landlord. Whenever possible, we contact the landlord before admission of the tenant and attempt to get an agreement whereby the tenant allows the landlord to advance the cost of the hospital care until the crops are harvested.

FEDERAL AGENCIES HELP

Failing in the foregoing effort to collect from a tenant who we feel is able to pay, we turn to the county farm agent's office. The Soil Conservation Act grants a rental check to the tenant in the early spring. This is based on the number of acres cultivated by the tenant and is assignable by him for certain services, hospitalization being one of these.

Another federal agency, the Farm Security Administration, is of much help in the tenant problem. This is an agency created to finance and supervise the marginal tenant. Whenever practical it has been cooperative in making loans to its tenants to defray costs of hospital care. Some of its families are submarginal and must be classed as charity. In such cases we accept the recommendation and make no effort to collect. This is a point to be strictly adhered to throughout the hospital's collecting problem.

Clipping notices of appointments of estate executors and administrators from the local papers has proved to be a profitable pastime. They are checked with our account cards to see if the estate owes the hospital. Under the statutes, a bill must be presented to the administrator of an estate within one year from publication of such appointment or collection is barred. By watching for such announcements the hospital is on guard against forfeiture of its rights.

INTEREST CIVIC ORGANIZATIONS

Another source of funds having to do more with the charity patient than the borderline patient is the various charity and civic organizations. The local chapter for infantile paralysis has funds that can be paid for hospitalization of patients afflicted with infantile paralysis. The local Red Cross chapter can expend funds to hospitals; in our case, it buys drugs for charity patients. Money from tuberculosis seal sales can be used for payment for x-ray work on suspected cases. Various women's clubs and civic clubs have funds for certain hospital work. Our Kiwanis club pays for a fixed number of tonsillectomies each year.

These organizations represent a fertile field for aid in carrying the charity load, but it is a field requiring intensive cultivation. The administrator must find these sources and interest them in some special activity.

All of the foregoing deals primarily with making a pay patient from a semicharity patient. We still have our share of charity, but it is genuine charity. We have simply tried to take hold of the problem in such a manner that the hospital, the patient and the public will be pleased and benefited.

THERE IS *NO* EXCUSE

For Tuberculous Infection

CATHERINE WEST, M.D., LOIS SCHALLER, R.N., and J. ARTHUR MYERS, M.D.

NO LONGER is there any excuse for the general hospital to permit the spread of tuberculosis among patients and personnel. The general hospital can operate a small tuberculosis service at an extremely low cost and the importance of such a service is high no matter how many vacant beds may be available in a sanatorium in the same district.

The work of such a service is different from that of a sanatorium and in no way conflicts with it because it is too small to have any material effect on the sanatorium and because it transfers the patients to the sanatorium when they are found in need of such care. Of great importance is differential diagnosis, which spares many persons the stigmata of a sanatorium record.

In February 1938 a special tuberculosis service was established in the Minneapolis General Hospital and was housed in the contagious disease building. Activitics of the first year of this service were reported in The MODERN HOSPITAL in the issues for January, February and April 1940. The present report covers the period from Feb. 1, 1940, to Feb. 1, 1941, during which time there were 166 adult admissions.

The total number of days these patients were housed on this service was 2410, an average of 14.52 days per admission. However, 148 of the 166 admissions remained less than a month, or a total of 1493 days, an average of 10.09 days.

Eighteen patients were in the hospital for a total of 917 days, an average of 50.94 days. The latter group consisted of persons who presented difficult problems in diagnosis; in fact, animal inoculations were often required. Some of them were transients and considerable time was necessary to establish residence so that the proper isolation and care would be ensured.

One hundred and three of our patients had attained the age of 40 years or more, of whom 35 were 60 years or older.

The relapsing nature of tuberculosis is evident from the fact that 83 (49 per cent) of our admissions were recorded as having had previous diagnoses or treatments for tuberculosis.

The tuberculin test is of extreme value in the diagnosis of tuberculosis at all ages of life and should be the first diagnostic procedure in every case.

The x-ray film inspection of the chest was used extensively to locate lesions and to study their extent and any changes that might occur in them. In no case was a diagnosis made from x-ray film inspection alone; it was considered only a part of the examination and too crude for the determination of etiology.

No symptom is pathopneumonic of tuberculosis. For example, on admission 25 patients were having hemoptyses, varying from streaks of blood to frank hemorrhages. Of these, 12 were found to have definite pulmonary tuberculosis; four had pneumonia; four had bronchiectasis, and five had cardiac conditions in decompensation.

The usual physical examination of the chest was employed in each case, but in minimal lesions physical signs often were absent.

It is only laboratory procedures that determine with accuracy the etiology of chest disease, whether it is due to malignancy, fungi or bacteria. In 25 cases we had to resort to gastric lavage in our search for tubercle bacilli. The finding of acid-fast organisms in the sputum does not necessarily constitute a diagnosis of tuberculosis, since there are a number of saphrophytes present in certain foods, such as butter, which appear identical to tubercle bacilli on microscopic inspection. Therefore, animal inoculations from sputum, gastric contents, pleural, peritoneal and spinal fluid, and urine have been used as indicated. Bronchoscopy was necessary in some cases to visualize lesions or to procure material for microscopic inspection or inoculation.

It is an extremely serious matter to diagnose tuberculosis without sufficient evidence. With the present awareness of the public to the con-

From Minneapolis General Hospital, Departments of Medicine and Preventive Medicine, University of Minnesota, and the Lymanhurst Health Center, Minneapolis. Prepared with the aid of a grant from the medical research fund of the University of Minnesota.

tagiousness of the disease, individuals may lose their positions and find it difficult to procure others because of a diagnosis of tuberculosis.

The great value of a tuberculosis service in a general hospital is seen in the admitting and final diagnoses of our group of patients. Twenty-eight had entered the hospital for other conditions but were found to have coexisting tuberculosis, 21 of whom had progressive disease. On the other hand, 27 were admitted as tuberculous and symptoms were found to be due to such conditions as bronchiectasis, malignancy, bronchitis, pneumonia, bronchial asthma and cardiac affections. Without such a service these patients probably would have been admitted to sanatoriums.

Seventeen patients died on the service during the year; 26 were referred to other services in the hospital; 68 were returned to their homes; 51 were sent to sanatoriums, and four were returned to the workhouse or police department.

ARTIFICIAL PNEUMOTHORAX USED

For the most part, treatment was limited to urgent needs of the patients. All were treated on strict bed rest. To stop hemorrhage or to control the disease as soon as possible while arrangements were being made for the disposition of patients, artificial pneumothorax was instituted in some cases. This also had the distinct advantage of rendering the sputum negative for tubercle bacilli for the safety of the personnel. In other cases, artificial pneumothorax had been instituted elsewhere and the treatments were continued while on our service.

The cost of operating a small tuberculosis service in a general hospital is extremely small. For example, the laboratory examinations, including x-ray film inspections, are those that are being done regularly in any good general hospital; the food costs are essentially the same as in other parts of the institution. The average daily cost per patient in the Minneapolis General Hospital as a whole is in the neighborhood of $5.50. Obviously, certain departments are operated at great expense: surgery requires expensive supplies; the pneumonia service uses oxygen and antipneumococcic serum; the emergency ambulance service adds to the cost; blood banks must be maintained; a heavy out-patient department is expensive. These services should not be charged to the tuberculosis service, which rarely, if ever, uses them. Indeed, during the first year of operation of our service the actual cost was less than $2 per day per patient.

One of the chief objects of our tuberculosis service is to demonstrate that it is possible to protect members of hospital personnel from tuberculosis by the use of strict contagious disease technic. Our patients are cared for under the same isolation technic that is used for all patients having communicable diseases. Each patient's unit consists of a bed, chair, bedside table and an equipment shelf in a service room which adjoins the ward. Since separate isolation technic is used for each patient, nothing in the ward except the patient's unit is considered contaminated; that is, screens, window sills, window shades and faucets on plumbing are all considered "clean."

Separate isolation technic is absolutely necessary, since many of the patients are admitted with tentative diagnoses. All members of the hospital personnel wear masks when they enter the ward; whenever they work directly with a patient they wear an isolation gown.

In addition to this, the patients wear masks while they are being cared for and whenever they are transported to another department, such as the x-ray department. An attempt is made to teach the patient to cover the mouth when coughing and to place the tissue directly into a paper bag to be burned. However, this is not effective for the mentally deficient, the uncooperative and seriously ill persons.

NURSES' AVERAGE DECREASES

In a previous report we called attention to the fact that of the student nurses who came to the service as nonreactors during the first year 11.2 per cent were reactors approximately six weeks after leaving the service. This percentage probably was unfair to the service because four of the 10 nurses who became reactors went immediately to a sanatorium or another institution on a tuberculosis service after completing our work. Thus, the percentage of nurses who we felt reasonably sure had contracted the disease on this service was only 6.6. This was much less than any report we had seen in the literature and indicated some degree of success.

From Aug. 7, 1939, to Dec. 9, 1940, a total of 260 student nurses entered this service, 109 of whom were already reactors when they entered. Of the 151 who were nonreactors, 10 (6.62 per cent) were found to react six weeks after leaving the service. However, four of these students transferred immediately from our service to a tuberculosis service in a sanatorium or other hospital. Therefore, in only six cases (3.96 per cent) have we reasonably definite proof that the infection occurred while on our service.

The annual infection attack rate in the general population of this vicinity is 1 per cent or less; therefore, the rate on our service is still too high. We believe the time is not far distant when students and other members of hospital personnel can work on a tuberculosis service without becoming infected or reinfected in sufficient numbers to create a serious problem.

RECOMMEND PERIODIC CHECKUPS

The staff of the tuberculosis service has recommended from time to time that every person employed and every student in the hospital be adequately examined for tuberculosis every six months. Anyone found to have progressive tuberculosis of the reinfection type should be treated immediately. An adequate examination for tuberculosis should be required by the institution for all persons employed in any capacity and periodically thereafter.

Since it is not unusual for patients admitted for diabetes, surgery and obstetrical care to have coexisting pulmonary tuberculosis, it has been strongly recommended that every patient who enters the hospital be adequately examined for this disease. The satisfaction experienced by the management and the responsible staff members in knowing that no patient is transmitting tuberculosis to other patients and to members of personnel justifies the expense. Moreover, patients found to have progressive tuberculosis previously unsuspected may have it treated successfully and may be prevented from innocently spreading it to others.

BOOKS *for everyone*

Maintaining a diversified collection of well-chosen books to satisfy the tastes of both young and old is a big order but it's the definition of success for the hospital library

HILDEGARDE LEMCKE
LIBRARIAN, ST. LUKE'S HOSPITAL, NEW YORK CITY

PATIENTS' libraries are an integral part of hospital therapy. To enable a patient to forget his sufferings by reading or to lure others back to interest in life through literature is, indeed, a stimulating service.

To develop fully this service for patients, it is necessary to survey the library from time to time, discarding old books, bringing the collection up to date, if funds permit, and building up new departments as needed.

Our library at St. Luke's serves both private and ward patients with books and magazines and is under the supervision of an experienced librarian. Circulation for the last six months was 3057 books. Because the budget is small, supplementary income is derived from the sale of old paper; good, but unsuitable, books are sold to specialized book dealers in the city.

The survey of our library, undertaken recently, showed the need for two projects to complete the service: books for foreign patients and revision of the juvenile library.

The problem of supplying books for foreign patients is a common one in libraries these days. According to the U. S. Department of Immigration, 80,000 refugees from Germany and the conquered lands are now living in the United States. A certain number of these are bound to be hospitalized; at St. Luke's 25 per cent of the patients were aliens at the time the survey was made.

If these people desire to learn English, there should be standard English language books for them. Lists of inexpensive books can be obtained from the Office of Education, Washington, D. C., from the Good Neighbor Committee, 2 West Sixty-Fourth Street, New York City, and from the Committee on Refugee Education, 254 Fourth Avenue, New York City. Others of the group may want books written in simplified English or novels of American life; the librarian should be familiar with these books.

Then, there are the aliens who read almost no English and who look to their own languages for comfort in illness. To select books for them presupposes a knowledge of foreign languages, which makes it necessary sometimes to call on specialists either in the public library or in other educational institutions. Foreign books are often unbound and inexpensive; they may be covered with colored paper both to strengthen them and to lure the prospective readers. A different color can be used for each language; color helps to brighten the truck and brings a quicker response.

The juvenile library should be selected with great care and only after a conference with the school teacher, if there is one, and the pediatric supervisor. The books must be light in weight, well illustrated and printed in large sized type. A broad, standard collection is advisable. Children come into contact with life earlier today and are more familiar with science and mechanics; the books in the juvenile library should satisfy these needs.

The greatest enemy to the reading of good children's books today is the wide circulation of juvenile comics. It is time that hospital librarians did something to discourage the reading of comics to the exclusion of other good reading matter. That they have human interest and bolster vocabularies cannot be denied, but the format is cheap and they encourage the child to form bad reading habits.

Humor and heroism, which have a special appeal to children, can be found in other sources. When planning the library purchases, include stories of true heroes, adventurers, soldiers, explorers and the humorous books of Lawson, Burgess, Bacon and others. In the hospital library the solution to the poor literature problem is storytelling and reading aloud from a good collection of juvenile books.

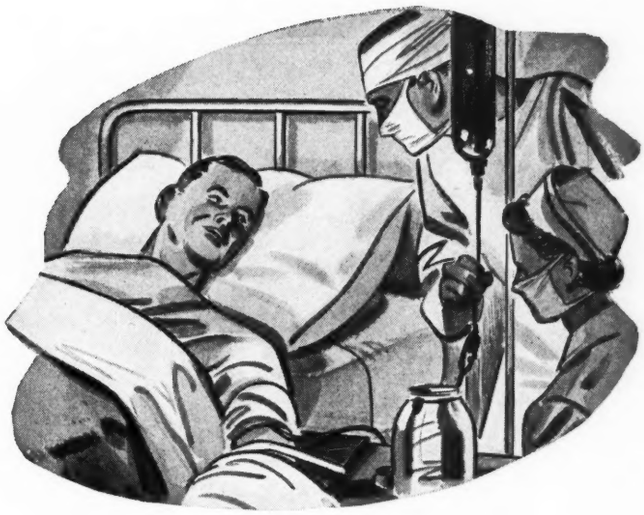
For the librarian untrained in children's literature, many aids are available. Before purchasing books, it is wise to submit the prospective list to a children's librarian. Both fiction and nonfiction books can be obtained from ten cents upward. The best basic source, the Children's Catalog, may be consulted in almost any library.

The following lists can be sent for by mail and all are backed by reliable sources: Newark Public Library, list of 100 books for children; Office of Education, Washington, D. C., 500 books for children, bulletin No. 11, 1939; Russell L. Reynolds, 197 Teaneck Road, Ridgefield, N. J., annotated list of inexpensive books from $0.10 to $1; Lincoln School of Teachers College, Columbia University, New York City, 30 picture scripts.

Of the magazines, *American Girl* and *Boys' Life* are excellent and wide in scope; they cost $1.50 annually. Some boys, if they are well advanced, can enjoy *Popular Science Monthly,* at $1.50, or *Popular Mechanics,* at $2.50. For the younger children, *Story Parade* and *Jack and Jill* are popular; the subscription rate for these magazines is $2. *Child Life,* at $2.50, is helpful but requires aid in working out the projects.

If colored posters are permitted on the walls of the wards (and many wards need more color), they may be obtained from the American Child Welfare Association, 70 Fifth Avenue, New York City, at $1 each. These posters make attractive decorations for children's wards.

Blood Banks save minutes that save LIVES!



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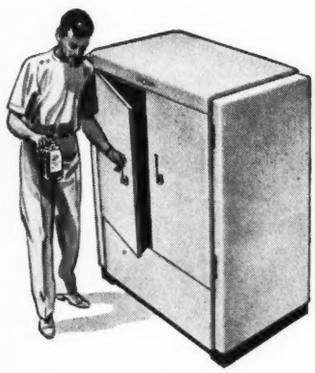

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GENERAL ELECTRIC

AIR CONDITIONING AND COMMERCIAL REFRIGERATION

Shall I Call Him "John"?

If he is one of your trustees, it's not a good idea, most of these small hospital administrators agree. However, a simple code of ethics adapted to the individual situation is advocated as the best basis for relations with trustees

A SURPRISING degree of unanimity was found among administrators who responded to the questions in this month's Small Hospital Forum concerning the relationships that should exist between the administrator and the board of trustees. To avoid any possible embarrassment, the names of those who replied to the questionnaire will not be used this month.

"To what extent should the administrator establish social relationships with individual board members?"

The answers to this question are as follows:

"Congenial social relationship with every member of the board but intimate social relationship with no member of the board or his family."

"I believe that it is better for the administrator to keep his relationship with all trustees on a business-like basis, if possible. There is less danger of friction should there be a disagreement over policies of administration."

"Social contacts with board members should always remain at a level that leaves both parties independent in their relation to hospital affairs."

"Impartial, friendly relationship; familiarity at all times should be discouraged."

"He should not form any social relationships with board members."

"In a small community, where the small hospitals are frequently found, it becomes difficult to attend any social function without finding at least one board member there. However, I believe it very poor taste to establish close social relationships with any one individual board member."

"As little as is tactfully possible."

"None. Treat all trustees as members of an official group."

"Very little. Personally, while I am on friendly terms with many of my board members and belong to the same country club, I have been careful not to use my position to advance my social contacts."

The second question finds somewhat more diversity of opinion. It reads: "Should the administrator discuss hospital affairs with board members outside the hospital, other than occasions especially designated for such purpose?"

"Yes, if it is agreeable to both and if the discussion receives the privacy it deserves. The board member and the administrator each should be mindful of the rights of the other and should not bring to the point of discussion matters that might be objectionable. Certainly the administrator should be careful of this practice when talking with the board members."

"Yes, if the board member introduces the subject; otherwise, no."

"There should be no objection. The psychological moment for some suggestion might easily appear outside the office. Lay people (including trustees) constantly seek information regarding the conduct of a hospital. The administrator can give information that will influence public opinion in favor of his institution without, at any time, betraying a patient's confidence. The public fails to be interested only in an institution of which it knows little or nothing."

"Not a good policy. Usually causes unpleasant feeling among those not contacted."

"No, except possibly with the president of the board."

"He should not discuss any of the hospital's business with any board member, except the chairman, outside the hospital and any action taken by the administrator and chairman should be reported to the other members when they meet."

"Sometimes it is necessary and essential to discuss affairs with board members outside the hospital and on other than occasions especially designated. In such trying times as the present where each trustee practically has to reorganize his own business, a few minutes consulting with him now and then, here and there, is of more value than if the trustee is not consulted at all."

"As occasion necessitates."

"Why not? I often do."

"No." (Two gave this answer.)

From these answers it would seem that it is not only permissible but often necessary to consult trustees outside of board meetings in order to take advantage of the right time for suggestions. But such conferences should not be carried on surreptitiously, should not usurp the function of board meetings and should not concern themselves with personal gossip. Many administrators have found that conferences outside of board meetings are necessary and important tools for educating trustees.

The third question was: "Should the administrator join the local golf club or other social groups? If so, to what degree should he fraternize?"

"If he can afford to belong to the local golf club or to other social groups, yes. He certainly has the rights of any American citizen to the degree of his ability to pay his way. There is a happy medium that all business men and women should not overstep in fraternizing. The hospital administrator has a delicate balance to maintain."

"I believe that the administrator might join some social groups but I believe that he would be criticized if he permitted his social activities to take up too much of his time during the day."

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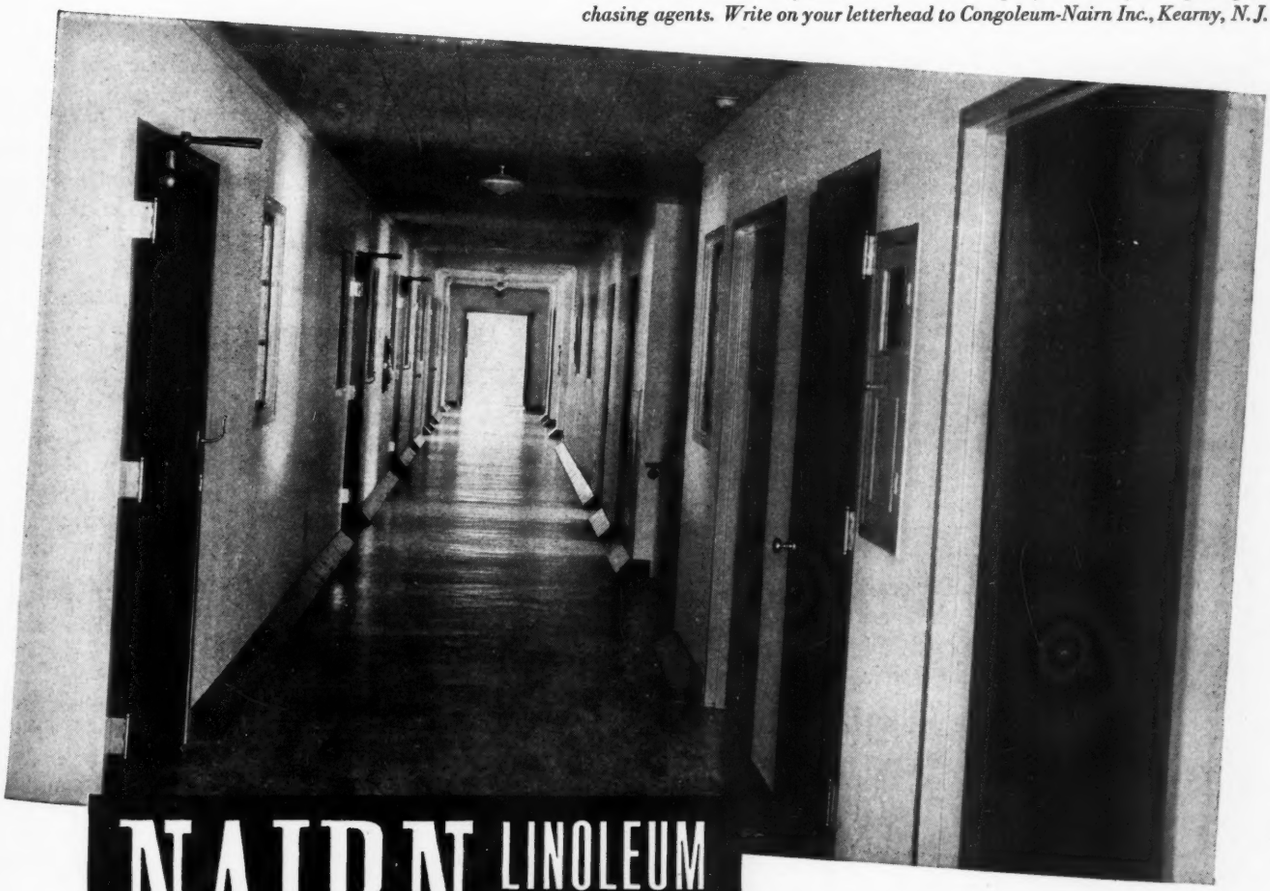

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FLOORS AND WALLS
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Balch-Elliott Hospital, Manchester, N. H., uses Nairn linoleum in corridors for its sanitary, easy cleaning properties, foot quiet, long wear—and warm, rich color effect.
Nairn Linoleum—the floor that gives you "all 4"

"Should be no objection. But never put business activities under obligation to the social activities. Acceptance of social responsibilities gives a hospital administrator the most advantageous opportunity to spread good will for his institution by his own personality and his ability to influence people."

"Yes. The administrator should have all privileges of social activities and clubs. An ethical administrator will not abuse his social rights."

"Yes, he should have social contacts and join whatever clubs he chooses."

"I think it is fine for the administrator to join the local golf club and other social groups if he can keep in mind that his responsibility, the hospital, comes first."

"The administrator has a right to live his own life. If he enjoys golf and can afford it, he should join a golf club. He should join any organization that his membership will benefit or from which he will receive benefit. If he makes a place for himself in the community, he advances the position of his hospital. If he is a leader in community affairs, the public invariably associates the hospital with his name and it is good advertising. Fraternize? No."

The fourth question brought almost unanimous agreement that the administrator should not call the trustees by their given names or permit himself to be so addressed. One administrator qualified it by saying "unless the trustees are friends of long standing."

The only other exception was an administrator who wrote: "I think this depends upon circumstances. Personally, I do and the members of my board always call me by my first name. However, I have been in this position for twenty years and have been associated with many of my board members in other civic affairs both before and after they became trustees of the hospital. The primary object of both the board and the administrator is to develop the institution for community service; whether relations are formal or informal is not paramount."

This seems like good sense. Probably, also, age and sex make a difference. One of the leading hospital administrators in the United States once stated that he never permitted himself to use given names of any members of his medical staff or trustees who were older than himself, even though he had known some of them intimately for thirty years. On the other hand, he did use given names of physicians younger than himself after he had come to know them well and to consider them personal friends, as well as colleagues. He does not use the given names, however, of any members of his board.

Obviously, circumstances and personalities differ so much that no general rule can be laid down unless it would be that a junior should not address a senior by his given name until given specific permission. Certainly, the dangers of too great familiarity are generally greater than the dangers of a slight excess of formality.

The final question was: "How can the administrator diplomatically handle social entanglements into which he may be thrust against his better judgment?"

This is not an easy question to answer in the abstract but some of the replies may be helpful, especially to the less experienced administrators.

"The hospital administrator can always be 'busy.' The community soon knows the social and moral standards of the person who has as prominent a position as the administrator; this knowledge in itself prevents the extension of many invitations that the administrator does not want. If he maintains those standards, he is not apt to be thrust into entanglements that are undesirable."

"He should try to solve the problem in such a way that the reputation of the hospital is not involved."

"His innate dignity and his professional bearing should prevent a recurrence of such a situation."

"Cautiously decline engagements where entanglements are likely to arise. When duty necessitates attendance, engage in general conversation where no discussion can involve you."

"A simple code of ethics should control each situation. This would vary with each occasion."

"If the administrator does not fraternize with his board, he won't get into embarrassing situations."

"If he is a tactful person, he does not have to approve or continue this relationship."

The code of hospital ethics, adopted by the A.C.H.A. and the A.H.A., states simply that the administrator's "attitude toward the trustees should be respectful at all times, refraining from partiality, from familiarity and from any violation of their confidence." Perhaps that is as good a summary as can be given.

WOMEN'S SERVICE GROUPS

They're Receptionists

Another mark of credit goes to auxiliary members with another service they are rendering ably. The work is that of receptionists on patients' floors; the hospital is the Methodist of Indianapolis; the auxiliary, its White Cross Guild. About 300 women (the guild totals 2500 members) have offered their services. First they undergo a period of training and orientation under the supervisor of nurses. Then they relieve the nurses of nonprofessional tasks, handling visitors, answering telephones and transmitting messages, delivering mail and helping keep supplies and charts in order. Some work one day a week, some two. When the plan is in full operation, 28 women uniformed in pink smocks with blue and white cross insignias will be working every day on the hospital's 14 floors.

Has Full-Time Director of Volunteers

New York's St. Luke's has taken a step that more and more women's auxiliaries will find wise. So many hospital tasks need doing and so many women want to do volunteer service during this war period that a Department of Volunteer Service has been created with a full-time director in charge.

To the director go all applications for volunteer work. She interviews the applicants, arranges for the necessary preparation, makes the placements and coordinates and supervises the workers.

Volunteer nurses' aides, Red Cross trained within St. Luke's walls, now number 43 graduates and 50 students. Of the graduates 37 work at St. Luke's and the others at neighboring hospitals. Staff members call them the Bluebirds because of the blue cotton jumper worn over the tailored white blouse.

Doctors on the Board?

"YES," Says

ARTHUR W. BINGHAM, M.D.

TRUSTEE, ORANGE MEMORIAL HOSPITAL, ORANGE, N. J.

THE most important feature of the relationship between trustees and medical staff is cooperation. Its importance is clearly brought out by observing those hospitals in which it is lacking.

On many important questions the trustees and the medical staff take opposite sides. The medical staff tries to put something over on the trustees whenever it can and the trustees from an economic viewpoint try to hold the medical staff down to as little expense as possible. They seldom agree for they foster a spirit of antagonism arising from lack of information and understanding of one another's problems.

How can this friction be avoided and how can cooperation be obtained? I believe that, as the first step toward mutual understanding, the medical staff should be adequately represented on the board of trustees. Opinions vary as to what the ratio of physicians to laymen should be but it seems to me that there should be at least two doctors, preferably the president and vice president of the medical staff.

Physicians who, as representatives of the medical staff, have the opportunity of sitting with the trustees in their meetings will gain an insight into the management of the hospital that will influence them considerably in handling policies related to the medical staff. Since these men are elected by the medical staff to represent it, they must be physicians of standing who have the confidence of the staff; as such, they can do much to foster a spirit of cooperation.

If the president of the medical staff is changed every few years and if the vice president is changed every year, more members of the staff will have the opportunity of meeting with the board of trustees and will become familiar with its problems. The trustees must do their part by concurring in the decisions of the medical staff on medical questions, provided they do not affect the policy of the hospital unfavorably.

The medical staff should make all recommendations for appointment of physicians to the staff subject to the confirmation of the trustees and, unless there are good reasons for objecting, these recommendations should be favorably passed upon. Any problem strictly medical should be decided by the medical staff and

(*Continued on page* 86)

"NO," Says

ARTHUR A. FLEISHER

PRESIDENT, JEWISH HOSPITAL ASSOCIATION, PHILADELPHIA

IT IS, of course, important that the board of trustees be kept closely in contact with the medical functioning of the hospital, since it is responsible for every act committed or omitted in the care of the patient. It is important for the board to be fully informed as to the efficiency, training and ethics of the staff individually and collectively. It is equally necessary for the board to realize that staff efficiency can be measured in terms of length of hospital stay, crossed infections following operations, postmortem percentages and the number of contributions to the medical literature emanating from the hospital.

However, this information can be obtained by means of a joint conference committee in which both board and staff are represented. Staff disciplinary and investigative action and opinion can be obtained through a medical executive committee or some other body in which the staff and the board share responsibility for appointments. Moreover, in some institutions the administrator is medically trained or a medical director serves as a liaison officer between staff and board.

If a conference committee exists, not one but several staff members serve as contact officers; hence, the opinion of no single individual determines board action on medical matters. In some hospitals the qualifications of physicians for staff appointments are investigated by a committee of physicians variously termed as a credentials committee or a board advisory medical committee. It would seem, therefore, that the presence of a staff physician at board meetings is not essential for providing information on medical matters.

Physicians of all specialties possess a curious psychology. They are intensely interested in the scientific and practical angles of the treatment of disease. However, today as perhaps never before physicians must engage in keen competition with their colleagues in the advancement of their practice and in the spread of their influence in the community. This is not an unethical or commercial attitude, but the physician, be he young or old, can never stand still. He either advances or recedes in the development of his practice and, hence, in the size of his income.

(*Continued on page* 86)

An Appeal to the Civilian Hospitals and Surgeons of America

"... This office has requested the Division of Medical Sciences of the National Research Council to formulate and promote suitable measures which would encourage conservation of sutures in domestic surgical practice. It is felt that your organization, through its advertising and sales functions, can also assist materially in such a conservation program. Therefore, this office suggests that you consider such procedures as might contribute to this end."

CLIFFORD V. MORGAN
COL., MEDICAL CORPS.
A. N. M. B. CONTACT OFFICER
DRUGS RESOURCES ADVISORY COMMITTEE

In publishing this appeal, Lewis Manufacturing Co.—Bauer & Black pledges its support to the promotion of the Army and Navy Munitions Board program. Surgeons will find their own individual ways of cooperating—practices best suited to their personally preferred techniques. And hospitals, in joining with their staffs on this program, will no doubt discover many important savings that can be effected without any sacrifice at all.

Many have already suggested methods of conservation to our representatives who are in daily contact with the profession. And from these suggestions we submit the following ....

WAYS YOU CAN COMPLY WITH THE GOVERNMENT'S CONSERVATION PROGRAM

Step down at least one gauge—for example, where you are now accustomed to using size 2 plain and size 0 chromic, try sizes 1 and 00. Smaller sizes use fewer ribbons or ply, those saved will make more strands.

Open the "last" tube when it's needed—It is appreciated that the need for saving valuable seconds during the operation prompts the suture nurse to open plenty of catgut so it will be instantly available. But many times that "last" strand isn't needed, so 60" of catgut are thrown away. Your suture nurse can help you make economies by opening that "last" tube speedily *if* it's needed.

Ask your Curity salesman for his ideas on suture conservation as they apply to the particular requirements of your institution.

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"Yes," Says Doctor Bingham

(*Continued from page* 84)

approved by the trustees unless the expense in carrying it out would be too great.

One cause of dissension between staff and board is the poor financial position of many hospitals which makes it impossible to supply the equipment desired by the staff. It is the policy of some hospitals to adhere so closely to a limited budget that there are always inadequate nursing, poor food and lack of equipment, causing slower convalescence and fewer cures as well as dissatisfied patients and physicians. These hospitals are always struggling and no one is satisfied.

To illustrate the inadequacy of such procedure, we might contrast it with the case of a physician friend of mine who started to practice in a community in which the local physicians had neglected to keep up to date. He introduced modern methods and modern equipment that cost him considerable money. However, he cured his patients more quickly and charged more for his services. Before long he had a large practice although his fees were twice those of his colleagues.

The same is true of a hospital. If the proper equipment is supplied and if the physicians have what they need to work with, the patients will get better results and will pay the difference.

The physicians who represent the staff on the board of trustees should be encouraged to take part in all discussions, for their viewpoint is different from that of the trustees and many of their ideas are of value.

Every board of trustees has a number of members who have little knowledge of what actually goes on in their hospital. Yet these members discuss problems at the meetings and help make decisions. Physicians on the board would be able to give them information regarding some of the problems that might easily change their opinions. If the members of the medical staff know that their problems are being considered by the trustees and if they feel they are adequately represented at the meetings, they are likely to be better satisfied with the final ruling.

Some groups believe that the board of trustees and the medical staff should remain separate, each handling its own problems. Some physicians feel that way, perhaps not wishing to take any responsibility in the running of the hospital as long as they have a place to treat their patients.

However, it has been my privilege to serve a hospital that has always had one or more representatives of the staff on the board of trustees, recently five. These physicians are regular in attendance and take an active part in the discussions. They serve on committees and give valuable advice. They are an important addition to the board of trustees and, as such, have the confidence of the other trustees as well as of the staff.

This relationship leads to the ideal cooperation of the staff and trustees and promotes complete harmony in the hospital.

"No," Says Mr. Fleisher

(*Continued from page* 84)

Unfortunately, sometimes doctors are excessively watchful to prevent any favoritism in the hospital. When a staff physician is selected as a member of the hospital's board of trustees, he is placed in a position in which he must continually serve as the counsel for his colleagues. If policies adopted by the board appear to be embarrassing to the staff, he may well be asked why he did not prevent such an enactment. His colleagues on the staff may willfully choose to believe that he voted with his colleagues on the board against the staff in order to curry favor and that, in effect, he sold his colleagues "down the river."

On the other hand, the doctor may be unduly cautious in his replies to questions asked him in board meetings, not caring to commit the staff in any way. His influence in such an instance would be negligible and he could only serve as a reporter to his staff colleagues as to what occurred in the board meeting. Sometimes, even, he is made to feel that he is not wholly welcome at board meetings and that discussion concerning staff matters is not as full and as frank in his presence as it would be otherwise. All in all, I do not believe that it is fair to adopt any system that embarrasses any staff member. In the light of what already has been said I am of the opinion that a physician's presence at board meetings adds nothing to the individual patient's chance to recover quickly.

Misunderstanding or any degree of jealousy occurring in board or staff organizations has a strong tendency to lower institutional morale. There is no more dangerous incident in the life of a hospital than the injection of personalities into any group. It is the time-proved principle that if favors are to be shown to any individual in a group they must be granted to the whole group. The wise superintendent will not entertain in his home or invite to the theater any member of the resident, nursing or even visiting staff group unless he so compliments the whole group.

To select an individual staff man and place him in a position of prominence and influence is likely to give rise to the claim that this physician is endeavoring to obtain perquisites for himself or for his own department at the expense of others. If he is a surgical specialist of some type he may be tempted to submit arguments why his department should be reequipped or if he does not originate such requests he may be inclined to provide substantiating data as to why a new apparatus should be purchased for his department or to depict the beneficial effect on the public of an outstanding department over which he has charge. Human nature is the same the world over.

I have endeavored to present my opinion as a matter of principle only, realizing that in many splendid hospitals staff men are members of boards of trustees and some good effects result from this policy. Such incidents I consider exceptions that prove the rule.

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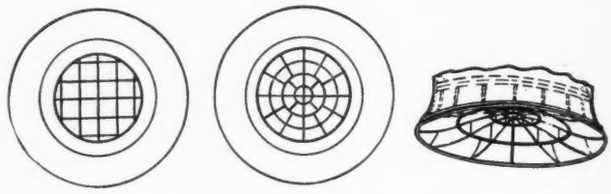
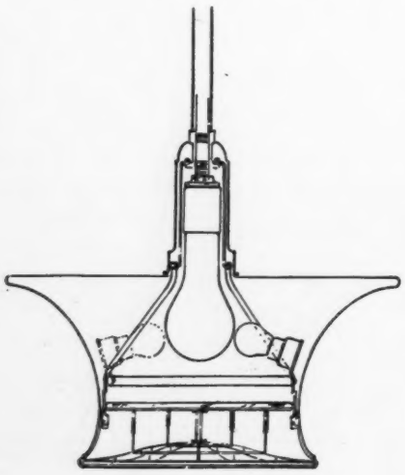


The louvered direct-indirect fixture, vertical section of which is shown below, can be fitted with glare baffles such as those illustrated at right.

AT a hospital director's request for a glareless light for use in wards, we devised the fixture shown in the accompanying illustration. Fortunately, the principles involved in good hospital lighting are much the same as those needed for war-time protective lighting. The lighting given by this fixture is a new type, which may be called louvered direct-indirect. The purpose was to devise a fixture that would combine all the advantages of direct and indirect lighting and at the same time correct as far as possible their faults and deficiencies.

In indirect lighting the ceiling and upper part of the room are too light and the lower part is too dark. In direct lighting the converse is true. In our fixture, an aperture of suitable size at the bottom of an indirect fixture allows part of the light to pass downward. In order that the proportion passing in either direction may be varied as desired, a socket adjuster is provided for changing the height of the lamp in the fixture.

All glare and high brightness are completely eliminated from the source of light, the fixture and every part of the field of vision. In indirect lighting the intention is to protect the eyes from glare by turning the opening of the reflector toward the ceiling. In order to get enough light on the plane of work the ceiling, in most cases, must be made too bright, thus creating a secondary source of glare. This, although better than the glare from bright lights, is not good, especially in hospitals, where the ceiling forms a large part of the patient's field of vision. If a part of the light is allowed to pass downward, the ceiling need not be made harmfully bright in order to give enough light on the working plane and on objects in the middle and lower parts of the room.[1]



Other troublesome sources of glare in indirect lighting are the neck of the lamp, the socket and the metal parts above, highlighted from the upper part of the bulb. This we have guarded against by enclosing the neck of the lamp in a narrow tubular shield flaring at the bottom.

In totally direct lighting, there is no protection from the glare of the opening of the reflector. In our fixture, glare protection is afforded in every direction (except looking upward from directly or almost directly beneath the fixture) by a glare baffle or louver construction across the opening in the bottom of the fixture. The protection is made complete by surfacing all parts of the louver in mat black. So surfaced, no higher brightness than a soft silvery sheen is seen, even when a high wattage lamp is used.

[1]In this connection, it may be said that enough light is thrown directly beneath the fixture to read a thermometer and to make and read notes. This would be wholly impossible with indirect lighting.

The light gives a high degree of diffuseness. The upward component of light undergoes one or more reflections before it reaches the working plane and the eyes of the patient. This is one of the best features of indirect lighting. The downward component of light passes through a diffusing means, which should be the best obtainable and positioned as closely as possible above the baffle construction. Thus, a soft evenly distributed illumination is obtained.

The light is confined to the room illuminated as far as is possible with any fixture construction that would be acceptable in good hospital lighting. The light passing vertically upward is reflected downward and the light passing obliquely upward is reflected by the ceiling to the upper walls and from there back into the room. The light passing downward is confined to the vertical or near vertical by the louver construction across the opening in the bottom of the fixture. Thus, no light is radiated directly through the windows and comparatively little reflected light passes through them.

There is a pressing need in hospital lighting for an auxiliary night light of such low intensity that it will not prevent patients from sleeping or disturb patients who are asleep. In the fixture shown here, this is provided for by two small lamps in diametrically opposite positions within the fixture. These lamps should be of the lowest possible

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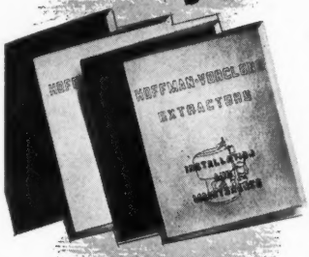

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wattage and on a separate circuit from the primary lamp. Two lamps are used instead of one so that no shadow will be cast on the ceiling by the primary lamp. For war-time protection, the night light should have insufficient power to penetrate the external atmosphere; hence, the bulbs should be of dark blue glass or be colored by a dark blue heat-resisting dip.[2]

In addition to its protective value, this type of illumination, when the intensity is low and the bulbs are suitably colored, has the advantage of giving a dim moonlight effect that is soothing and somnolent to the patient. With this combination of night lamps and fixture, little, if any, special curtaining is needed to give an effective blackout. The combination is more than adequate for what is called semiblackout war-time lighting.

If in order to decrease both the amount and spread of the illumination it should be desirable to shut off completely the upward component in the night light, this can be accomplished by blacking or otherwise lightproofing the upper half of the bulbs. Further, by extending the blacking, the downward component may be reduced to as near the threshold of vision as may be wanted. With this treatment of the night lamps in conjunction with the light confining action of the fixture, every possible degree of blackout may be produced without resorting to special curtaining. The lamps that are used with this method of controlling the intensity and spread of the illumination may, of course, be colorless or of any color desired.

[2]Besides penetrative power, there should also be taken into consideration the eye factors: the comparative sensitivity of the eye to colored lights at very low intensities, visual acuity at low intensity and the adaptation factors. Principally because of the eye factors, deep red has been suggested as an alternative to dark blue light. This, however, would hardly be acceptable in hospital lighting. We have used with considerable satisfaction light approximating the color of a low-brightness kerosene flame for a night light. This is not too unpleasant and is distinctly somnolent. The possibility of using heavily frosted colorless bulbs should not, of course, be completely ignored. However, without the use of color in the bulb, it is difficult to get light of sufficiently low intensity with the lamps that are available.

Engineers' Question Box

Question 23: In a large ice-making machine, what density (specific gravity) should be maintained in the brine for most efficient operation of the machine? What is the most effective temperature of the brine? Does the answer depend upon the length of run of the brine lines?—D.P., Mich.

ANSWER 1: The specific gravity of brine for ice making should be between 80° and 85° Baumé (or 2.2 to 2.4 specific gravity) and the temperature of the brine should be between 12° F. and 14° F. If there are long runs of lines and a considerable amount of cooling of ice boxes by means of brine, the temperature should be carried between 10° F. and 14° F.—JOHN H. HERZOG, *San Francisco.*

ANSWER 2: Calcium chloride brine should not be less than 1.20 specific gravity and 59° test and not more than 1.24 specific gravity, as heavy brines require additional power to circulate. Temperature of the brine depends entirely upon length of the brine circuit and the amount of coil in each refrigerator or tank. Ice tanks for freezing ice should be 12° F. if they are to maintain the most effective temperature. Chemical conditions of brine are just as important as specific gravity; therefore, a test for acid and alkaline should be made. Ph value should be between 7 and 8.5. A capable man should test and recommend treatment, if any, thus avoiding corrosion and electrolysis.—JOHN A. DOHERTY, *Cambridge Hospital, Cambridge, Mass.*

ANSWER 3: In a large type of ice machine the specific gravity of the brine at 60° F. should be about 1.175 and brine at this density has a freezing point of about zero. Brine at this temperature near the machine will allow for a rise in temperature of 5° to 10° at the most remote points of circulation, which is sufficient for good refrigeration. This is the practice we follow with our CO_2 machine with good results. Brine of this density will not freeze tight around the block ice tanks and make it difficult to remove them.—WILLIAM J. MOMBERGER *Orange Memorial Hospital, Orange, N. J.*

ANSWER 4: The specific gravity or density of the brine should be at least 1.00 to 1.10 for most efficient operation. We find that best in our own plant.

The most effective temperature of the brine is 5° to 15° F. Most compressors will carry that low a temperature without overspeeding or overrating.

The answer does depend a great deal upon the length of run of the brine lines, but there is one important item left out. That is the use of an agitator to keep the brine in the tank in circulation; I mean the brine that directly surrounds the ice cans. Circulating or agitating the brine will increase the efficiency of the whole system.—LELAND J. MAMER, *Evanston Hospital, Evanston, Ill.*

Refrigeration Answer Takes the Prize

Although it was difficult to reach a decision, the answer by John A. Doherty, engineer of the Cambridge Hospital, Cambridge, Mass., was judged best of those published last month and the $5 award has been sent to him.

Have you some problems that are baffling? Have you worked out good answers to some of the problems that are bothering other people? Send both your own questions and your answers to the questions of others to: Engineers' Question Box, The MODERN HOSPITAL, 919 N. Michigan, Chicago.

Here are four more to try your teeth on:

41. How can we eliminate complaints of static in our radios resulting from fluorescent lighting equipment?—F.J., N.Y.

42. In this national emergency, how can I lengthen the life of the elevator hoist, governor and compensator cables of the elevators?—S.B., Iowa.

43. At what temperature should we carry the domestic hot water for the hospital as a whole? For the kitchen? For the laundry?—A.M., Sask.

44. Who should be responsible for the physical and mechanical condition of oxygen therapy equipment and why?—O.B., T.H.

TRAP THE NOISE DEMONS

. . . with ceilings of Armstrong's Cushiontone

IT'S BAD MANAGEMENT to let noise demons ruin the peace and quiet that are expected of a hospital. Staff work suffers, and patients' recovery is retarded, as long as these costly nerve janglers are on the loose. But it's easy to trap them with ceilings of Armstrong's Cushiontone — the new material that puts efficient noise-quieting within the reach of modest budgets.

The 484 sound-absorbing holes in each square foot of Armstrong's Cushiontone literally trap noise in corridors, wards, kitchens, and other busy areas. Sound engineers have found that this material absorbs up to 75% of the sound that strikes its surface. When it is installed the noise level in any hospital is remarkably reduced. You don't need fine instruments to show the difference. The effect is positive and pronounced.

Armstrong's Cushiontone is factory-painted, ready to apply. Installation is quick and easy, without undue interruption to routine. Maintenance is at a minimum, for Cushiontone resists the accumulation of dust and dirt, and it can be repainted whenever necessary without affecting its acoustical efficiency in the slightest. Its ivory-colored surface reflects light unusually well — helps to improve general illumination.

WRITE FOR THE FACTS—Our new booklet gives the whole story of Armstrong's Cushiontone. We should like to send you a copy. Just drop a note to Armstrong Cork Co., Building Materials Division, 1243 State Street, Lancaster, Pa.

Armstrong's Cushiontone

Made by the Armstrong's Linoleum (A) *Makers of and Asphalt Tile*

HOUSEKEEPING PROCEDURES

Conducted by Alta M. LaBelle

How Do You "Stack Up"?

Housekeepers might do well to check up on their methods of organization and operation occasionally to be sure that the department is being run as economically as possible. The following list of "points to remember" is suggested by Keith Taylor, administrative intern, Peralta Hospital, Oakland, Calif.

HAVE YOU—

1. Obtained the best help available in this field?
2. Laid down proper lines of authority so that there is no conflict with other departments?
3. Established standard practices and procedures for each job?
4. Provided for regular inspection of work and adequate supervision of personnel?
5. Emphasized the importance of the work of the housekeeping department so that maids and janitors feel that they are doing a real job and are not just drudges?

DO YOU—

1. Provide equipment of the proper type and quality for each job?
2. Teach each new person the proper way to use brooms, mops and other cleaning equipment?
3. Arrange periodic demonstrations of proper procedures and methods of cleaning?
4. Avoid waste of soaps and other cleaning materials by teaching employes how to use them correctly?
5. Make time and motion studies as bases for improved methods if the department seems not to be operating economically?
6. Economize in the use of linens and other fabrics by giving careful attention to their care both in use and in the laundry?
7. Instruct all employes in the importance of caring for goods and materials that are important in prosecuting the war successfully and are costly to replace?
8. Keep abreast of new developments and advances in the field and exchange ideas with other housekeepers?

●

Sample Work Schedules

Maintaining work schedules in these days when maids and porters are hard to get and harder to keep is a serious problem in the housekeeping department. However, Lillian Wright of St. John's Hospital, Brooklyn, N. Y., has found that posting work schedules in the lockers of her employes helps to maintain a smoothly running routine. The following lists are typical of the duties for the maids and porters at St. John's Hospital.

Maid: Medical and Surgical Wards

7:00—Clean three kitchens; clean three ice boxes.
8:00—Make beds and empty wastebaskets in old building.
9:00—Dust wards and tidy kitchens on both floors.
12:45—Clean kitchens.
2:00—Clean apartment in old building.
4:00—Clean all food carriers in hospital kitchens. Leave floor tidy for night nurses.
Monday Afternoon—Clean bathroom and dust hall.
Tuesday Afternoon—Tidy kitchen and bathroom of apartment in old building.
Wednesday—Off duty.
Thursday—Clean bathroom and kitchen of apartment in old building.
Friday—Clean kitchen of apartment in old building.
Saturday—General work.
Sunday Afternoon—Clean bathrooms and kitchens.

Porters: Fourth Floor Private Rooms

7:00—Take garbage to elevator. Sweep, dust, mop and clean 12 rooms. Polish corridor. Clean utility room, kitchen, bathroom, storeroom, open porches, linen room, special nurses' room. Polish brass on desk.
Monday Afternoon—Polish brass; empty garbage; oil wooden door; clean toilets.
Tuesday Afternoon—Scrub open porches; empty garbage; scrub kitchen, lockers and utility rooms.
Wednesday Afternoon—Clean all steel doors and brass. (To be done by relief porter.)
Thursday—Clean nickel in bathrooms and brass in kitchens.
Friday Afternoon—Clean toilets and brass; empty garbage.
Saturday—Clean brass.
Sunday—Clean nickel in toilets and clean and polish all marble and tile on floors.

Making Linen Control "Tick"

What is meant by linen control and who should be responsible for it?

C. V. Sadelmyer, director of laundry and linens at Albany Hospital, Albany, N. Y., feels that it is a job that requires the cooperation of every supervisor and department head.

"It has always been my object to protect the linen during the laundering and ironing processes," Mr. Sadelmyer explains, "but it is a severe handicap if supervisors and heads of departments do not enforce rigid rules for the preservation of linen.

"Such practices as using linen for cleaning purposes; wiping up medicines, which often have corrosive properties; keeping goods in the sterilizers longer than is necessary; using napkins for cleaning steam tables; using sheets and pillow cases for laundry bags, and keeping soiled linen in damp places where it becomes mildewed should be eliminated."

Another method of adding to the life of linen suggested by Mr. Sadelmyer is to give it a short rest before it is put back into service after being laundered.

"The cotton fibers in a sheet are subjected to stress and strain during the process of laundering and ironing. A rest period would give them a chance to readjust themselves and thereby lengthen the life of the sheet."

●

For Better Floor Maintenance

Check up on floor maintenance operations to be sure that the maintenance crew is getting the best results without wasting cleaning dollars, advises a floor maintenance expert. It is not always true, he points out, that "the more you use, the better the results." Some cleaning preparations are highly concentrated so that the best results are obtained by using just a little. Any excess use of such a product is a waste not only of the material itself, but of money and time.

In waxing floors, the principal point to remember is not to set up rigid rules, such as "this floor must be waxed at a specified time." The chances are that some sections of the floor will not need to be waxed as often as others. Furthermore, thin coats of wax properly applied will usually give better results than piling on excessive amounts of material.

Now, more than ever before, it is necessary to protect new floors with the proper finish to ensure longer life, the expert warns. Old floors cannot be neglected either. Many of them can be coaxed to last through the war with adequate care.

At Chicago's New "Cathedral of Healing"

. . . KELLOGG'S INDIVIDUALS . . .

are always on the morning menu

● All over the country leading hospitals are serving Kellogg's Individuals daily. There are four important reasons why:

First . . . patients like the idea of opening a generous individual package of their favorite Kellogg Cereal. They like the wide variety, the perfect freshness.

Second . . . every Kellogg Cereal is made from *whole grain*, or is restored to *whole grain nutritive values*, as recommended by the U. S. Official Nutrition Food Rules. An important dietary help.

Third . . . Kellogg's Individuals reduce kitchen work, make service faster.

Fourth . . . Kellogg's Individuals eliminate waste and allow exact cost control.

Specify Kellogg's Individuals when you order. Your wholesale grocer always has a fresh supply. Packed 50 to the case or 100 assorted.

ALL
Kellogg's
CEREALS
supply
WHOLE GRAIN
natural or restored
VALUES
as recommended by the
U.S. NUTRITION FOOD RULES

Feeding Army Patients

B. BERNICE BOWEN
DIETITIAN, FORT ORD, CALIF.

SERVICE in an Army hospital offers the dietitian with initiative an unprecedented opportunity to demonstrate her worth in an administrative and educational capacity. She can be of inestimable value both by making full utilization of her training and experience in these fields and by functioning as an aid to the medical service by furnishing therapeutic diets to patients who require them.

An Army hospital mess department is headed by a mess officer who is charged with the responsibility of management of the mess, the finances and accounts pertaining thereto. He is assisted administratively by a noncommissioned officer, who acts as mess steward, and the head dietitian. Because of the rapid expansion of the Army, a sufficient number of men who have the background of training and experience ordinarily required of a mess steward is lacking. It is important, therefore, that the Army dietitian be willing and able to assist the mess steward in all of his duties, which may overlap the duties ordinarily belonging to an administrative dietitian in a civilian hospital. By frequent conferences with the mess officer and mess steward the dietitian can be of invaluable assistance in organizing the department and training the personnel.

All dietitians entering Army service should familiarize themselves with Army regulations pertaining to the operation of hospital messes, methods of procurement of supplies and the basic nutritional requirements of the ration for active troops.

The Station Hospital at Fort Ord, Calif., has been in operation for more than a year. It has a bed capacity of 1500. The organization plan of the mess department was drawn up to fit our particular needs. Conditions differ at the various posts, depending on the size, location, transportation and marketing facilities, and the training and experience of the mess personnel. The dietitian must adapt herself to the situation in which she is to work.

The mess steward is in charge of the assignment of duties to enlisted and civilian personnel. He assists the mess officer in the placement of purchase orders for subsistence supplies and with accounts kept by the mess. Noncommissioned officers in charge of the messes, warehouse and transportation are directly responsible to him.

The head dietitian plans general menus ten days in advance and prepares requisitions daily for all perishable supplies. She supervises the preparation, service, storage and distribution of food in all messes. She assists the mess officer and mess steward in the procurement of supplies by furnishing estimates of the amounts needed and specifying grades desired. All food items that are procurable at the commissary are purchased from that source. Items not procurable are purchased on the open market at the discretion of the surgeon. This system provides the patient in an Army hospital with the best food of the widest variety that the market affords.

TYPICAL WARD MENU—REGULAR

Station Hospital
Fort Ord, Calif.

Breakfast
- Bananas
- Grapenut meal
- Dry cereal
- Fried eggs
- Hashed brown potatoes
- Toast and jam
- Coffee, milk

Dinner
- Chicken-rice soup
- Veal cutlets
- Candied sweet potatoes
- Swiss chard
- Pear-peanut butter salad
- Bread and butter
- Raspberry sherbet
- Homemade cookies
- Buttermilk

Supper
- Soup, crackers
- Shredded chicken with noodles
- Whole kernel corn
- Creole eggplant
- Head lettuce with French dressing
- Hot rolls, butter
- Cherry cobbler
- Coffee, milk

A sergeant and a dietitian are in charge of each patients' mess. The sergeant is responsible for maintaining sanitation, receiving stores, issuing supplies to cooks and preserving order in the mess hall. He collaborates with the dietitian in ordering supplies daily from the warehouse and in supervising cafeteria service during meal hours.

The dietitian on duty in each patients' mess is in charge of food service to the wards and supervises the cafeteria service in the mess hall and the preparation and serving of special diets. Food is sent to the wards in food carts. Additional containers are used for cold foods. By having the food containers preheated with boiling water before being brought to the mess there has been little difficulty in having food warm when it reaches the patient. Approximately half of the patients go to the mess hall for their meals.

All special diets for both messes are planned by one dietitian, who also acts as an assistant to the head dietitian. As there is no provision for a special diet kitchen, therapeutic diets are prepared in the main kitchen. Approximately 100 patients are being served therapeutic diets; about three fourths of these are ambulatory patients. When more than three patients are being given the same diet they are served from the steam table, cafeteria style. Smaller numbers are served at tables

Soldier Patients Like These Salads

COLESLAW:

Yankee Coleslaw—Shredded cabbage with hot Yankee slaw dressing.

Shredded Coleslaw — Mayonnaise and seasoning of salt, vinegar and sugar.

Chopped Coleslaw—Diced celery, diluted vinegar, sugar, salt and pepper.

Cream Coleslaw — Shredded or chopped with sweet or sour cream, vinegar, sugar, pepper or salt. Cream should be partly whipped.

Pineapple Coleslaw — Shredded cabbage, diced pineapple, mayonnaise, marshmallows for variety.

Golden Coleslaw—Shredded carrots, cabbage with vinegar, sugar, salt, pepper or seasoned mayonnaise.

Shredded Lettuce—Relish, green pepper, vinegar, pepper, salt, sugar.

HEAD LETTUCE

Large Heads (40 to crate)—Cut six segments from each head.

Small Heads (60 to crate)—Cut four segments from each head.

Dressings: French; chiffonade; Russian; mayonnaise; 1000 island; chili-French.

MISCELLANEOUS VEGETABLE SALADS:

Spring Salad—Endive, lettuce, sliced radishes, green onions, tomato sections, green pepper strips, sliced cucumbers. French dressing.

Salad Bowl—Lettuce, tomatoes, cucumbers, raw carrot strips, any fresh greens. French dressing.

Lettuce-Tomato-Cheese — Lettuce, tomato sections, cheese strips. French dressing.

Italian Salad Bowl—Boiled ham, celery, raw carrots, green peppers, sliced onions, chopped parsley, chopped watercress. French dressing.

Piquant Egg Salad—Hard cooked egg, cucumbers, sweet pickles, tomatoes, lettuce, celery. Mayonnaise.

Chef's Salad—Raw carrot shredded, cooked beet strips, crisp bacon or shredded ham, cheese strips, sliced radishes, green onions and salad greens. Italian dressing.

Italian Potato Salad—Diced boiled white potatoes, dill pickles, diced raw apples, diced celery, diced cold boiled ham, onions, chopped fine, mayonnaise, pepper, vinegar.

Club Salad—Cooked macaroni, hard cooked eggs (20 per 100 people) ripe olives, chopped pickles, diced celery, chopped pimientoes, chopped green peppers, chopped parsley, grated onions, mayonnaise, vinegar.

Hot Potato Salad—Cooked sliced potatoes, chopped onions, cubed celery, raw bacon cut in 1 inch pieces, cider vinegar, water, sugar. Cook bacon until slightly browned and remove bacon crisps. Add flour to bacon fat; when thoroughly mixed, remove from direct heat and add vinegar, water, sugar. When well mixed, heat again and cook until boiling. Pour this over mixture. Serve warm.

Potato Salad—Sliced cooked potatoes with diced celery, sweet pickle, hard cooked eggs and small amount finely chopped onion. Mayonnaise (seasoning added) or boiled dressing. Add for variety pimiento or finely chopped green pepper.

Combination Salad No. 1—Cooked string beans, carrots, peas, asparagus, raw lettuce, celery, onions. French dressing or chili sauce and French dressing.

Combination Salad No. 2—Diced cooked carrots, green beans, kidney beans, peas, cucumbers, celery, shredded cabbage, mayonnaise and seasoning. Cucumbers may be omitted. Mix with mayonnaise or French dressing.

Peas, Cheese, Celery—Peas, shredded American or Swiss cheese (diced ¼ inch), celery, pickle relish, mayonnaise on lettuce.

Pickled Beet-Onion—Pickled beets with onion rings on lettuce.

Beet, Egg and Celery—Diced beets, hard cooked eggs and celery on lettuce with mayonnaise.

FRUIT SALADS:

Hungarian Fruit Salad—Oranges, bananas, pineapple, celery. Fruit salad dressing.

Waldorf Special—Diced apples, celery, nuts, marshmallows, Royal Anne cherries. Fruit salad dressing.

Panama Fruit Salad—Canned apricots, peaches, cherries, pears, pineapple.

Stuffed Celery—Filled with American cheese, cottage cheese or cream cheese.

with trays prepared in the kitchen. Nonambulatory special diet patients are visited as required by the dietitian who plans their meals. Regular ward rounds are made twice weekly by the relief dietitian. The mess officer and the head dietitian also visit the wards periodically in order to maintain close collaboration with the ward surgeons and nurses.

Military personnel is rotated frequently in order to train as many men in mess work as possible. In this respect a diplomatic dietitian can be helpful. Lectures on nutrition are given by a dietitian to members of the medical detachment in conjunction with their other classwork.

In planning menus it is necessary to take into consideration the value of the ration. Patients are allowed one and one half times the value of the garrison ration. This allowance is sufficiently liberal to place few restrictions on menu planning. By keeping waste to a minimum and by careful requisitioning of perishable subsistence items, the mess can be operated economically, thus permitting the food served to be of the highest quality and providing ample variety of all seasonal foods. Patients remain in the hospital during their entire convalescent period; therefore, the regular diet is designed to meet the needs of a normal healthy soldier. The constant aim of the dietary department is to aid in returning the soldier patient to duty in perfect physical condition.

Every effort is made to educate cooks and mess attendants in methods of cookery and food handling that will preserve food values. As the quantities prepared are large, careful planning of menus is necessary to assist the cooks in arranging their work so that food need not be prepared too far in advance.

Dietitians with the "will to do" will find much opportunity for professional growth in Army service. The proper viewpoint is one that recognizes the functional relationship between the dietitian and other personnel; the Army dietitian must learn to distinguish between those responsibilities that belong directly to her and those in which she is of supplementary aid. This does not mean that the dietitian is subservient but that she is coordinating her work with that of others with whom she works.

It Pays to Buy Right

PHILIP G. ZARAMBA

STEWARD, RUTLAND STATE SANATORIUM, RUTLAND, MASS.

IN ALL phases of purchasing procedure it is comforting to know that we are proceeding wisely. If a little thought and study are directed to the interpretation of food specifications to increase efficiency, then the time and effort involved should pay dividends in the knowledge that what we pay for is what we receive.

In a recent sectional survey of hospitals to determine if any established uniform standard of procedure for food purchasing existed, the following questions were asked pertaining to fruit, vegetables, meat and fish:

1. Do you obtain bids?
2. Are they written or by telephone?
3. How often do you buy?
4. What specifications do you use?
5. What grades are purchased?
6. Does anyone in your organization make personal contacts with wholesalers and make personal selection?
7. Who is responsible for checking the weights, conditions and grade upon deliveries?
8. Do you at times subscribe and pay for a grading service by the Department of Agriculture?

METHODS VARY, STUDY SHOWS

This study revealed that no general practice was being followed. All the hospitals obtained bids, either written or by telephone, and, in most instances, someone in the organization made personal selections. Others did this occasionally when time permitted. All institutions made someone responsible for checking deliveries, but, except for a few governmental and state agencies, these hospitals did not use the Department of Agriculture's grading service.

Replies to the questions about specifications used and grades purchased were varied. Some hospitals used their own specifications; grades purchased ran: "first grade," "A," "fancy," "good," "No. 1" and "best." A small percentage used U. S. Department of Agriculture specifications.

One standard grade for all hospitals would not be feasible owing to such factors as locality, type of institution and class of patient, but, once a grade is decided upon, adequate standard specifications should be adhered to covering proposals and checking deliveries. Bids should be drawn up in such a manner that all dealers will bid on the same quality or grade.

The U. S. Department of Agriculture has listed the requirements that must be met to ensure a certain quality of product. In some instances it is not compulsory for the grower to have the U. S. grade stamped on all fruit or produce or on all containers; however, brands, marks and labels do represent a certain quality in accordance with U. S. standards.

Because of the perishable nature of fruits and vegetables, the specifications may vary on a given item at a given time. A crate of California lettuce at shipping point may rate a grade of "U. S. Fancy," but, as the growers know, this same crate of lettuce will undoubtedly be graded U. S. 1 or lower if shipped to New York or Boston.

The principal variance between these two grades is that "U. S. Fancy" consists of heads of lettuce of similar varietal characteristics, fresh, firm and well formed, and in the "U. S. 1 grade," not less than 75 per cent of the heads of lettuce of iceberg type are firm. This regulation applies to most produce so that very little is sold as "U. S. Fancy" grade, if transported long distances. Some fruit and vegetables, such as apples, peppers and potatoes, that have good keeping quality characteristics are sold as a fancy grade if so rated.

For the purchase of fresh fruits and vegetables, consider the following important points.

1. Patronize reputable dealers who carry the quality of merchandise suited to your particular needs. Most produce merchants cater to a "type" trade. Weed out undesirables and place orders with merchants who are honest and anxious to serve your needs.

2. While it is good business practice and a protection to both hospital and buyer to obtain competitive bids, do not consider these bids as final, but use them also as an index for market values pending personal inspection. Instruct merchants to submit prices on all grades carried, listing brands and marks if possible, size of package and net weights. Some items are packaged in standard crates, boxes or bags; others are packaged in jumbo size, and some in small or half size crates or boxes.

3. Spend more time in the market inspecting, selecting and asking questions. Become familiar with brands, labels and trademarks. Of great importance is the section of the country in which fruit or produce is grown. California and Arizona cantaloupe is rated better than Delaware or Virginia cantaloupe. Prices for Connecticut potatoes or onions do not compare with those for Maine potatoes or Texas and Michigan onions. Similarly, if bids are obtained on spinach, prices will vary on the Texas product as against that of Norfolk.

FRUIT GRADES NOT STANDARDIZED

Some parts of Florida will brand a box of oranges or grapefruit to sell at U. S. Combination, which means that this fruit grades not less than 40 per cent by count "U. S. No. 1" and the remainder "U. S. No. 2" grade, yet this mark will bring a better price than U. S. No. 1 grade fruit in another section of Florida. Other growers pool their fruit at a central agency and market under one label; consequently, at the terminal or auction, cars of fruit listed under one mark bring varying prices.

Florida fruit is also graded as

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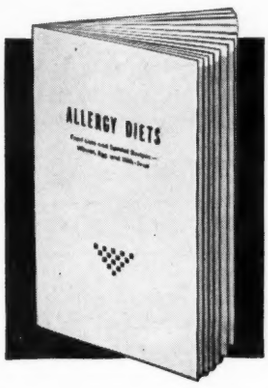
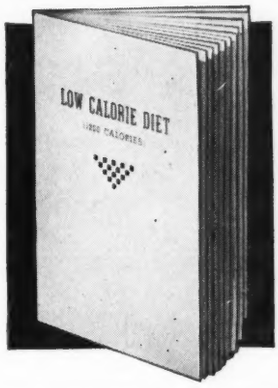


Complete Allergy Diets

All ready for use. Lists allowed and forbidden foods. Includes tested recipes for wheat, milk and egg-free diets. Made without wheat, milk or eggs, Ry-Krisp is a safe bread for those allergic to one or all three of these foods. Request diets on coupon below.



Simple Low-Calorie Diets

Dietetically sound. Widely used by doctors. 1700-calorie diets for men, 1200-calorie diets for women. Ry-Krisp indicated as bread because it has only 23 calories per wafer yet has a high hunger-satisfying value, provides bulk to aid regularity. Diets on request.

Eat Whole Grain Bread Regularly Is Advice of Nutrition Experts

Ry-Krisp is an out-and-out whole grain bread. Yields 7 International Units vitamin B_1 per 6.5 gram wafer, is a good source of iron, copper, phosphorus, manganese. A handy, delicious bread for everyone. Made of pure whole rye.

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Please send_____ copies Low-Calorie Diets and _____ copies of Allergy Diets. No cost.

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*City*_____ *State*_____

(Offer limited to U. S.)

"Brights," "Goldens" and "Russets." The eating quality of these grades may be practically the same; however, in appearance the "Bright" and "Golden" fruit is more attractive to the eye and brings a better market price. The smallest and largest fruits usually sell at a lower price than medium and large fruit.

The familiar trade name of California grown oranges ensures quality that meets "U. S. No. 1" specifications, yet, depending on the sections grown, general appearance, color, skin and taste, these trademarked oranges of one size vary in cost. Buyers at the Boston railroad terminal, where California fruit is auctioned, inspect rows upon rows of fruit, making notations for the quality desired before retiring to the buyers' room to await the hour for bidding to start.

The grading of meats by packers follows closely the specifications maintained by the U. S. Bureau of Agricultural Economics. Government graders brand beef as "U. S. Prime Steer," "U. S. Choice Heifer" or "U. S. Good Steer." An old method of designating quality of beef recognized differences owing to geographical origin, as well as to sex and grade. The term "Native" referred to cattle corn-fed in the Middle West. "Range-fed" cattle from the West and Northwest were known as "Westerns," while cattle similarly fed in Texas and the Southwest were called "Texans."

Although this terminology is still used to some extent by meat packers, it has been discarded in favor of a numerical system. One company designates "Prime or Show Stock" with the numbers 10 and 11; "Choice Grade," 12 and 13; "Good Grade," 13 and 14, and so on. Another packer starts with the number 30 and still another well-known house uses the number 20 to designate its prime stock. In each instance, the higher the number, the correspondingly lower the grade.

To simplify the grading of beef one step further, brand names are used and are stamped on the carcass. It is well to become familiar with these brands because they represent various grades of quality.

Lamb is also classified according to grade numbers and brands. One large packing house grades genuine spring lamb weighing from 30 to 39 pounds as No. 41; No. 42 grade will weigh from 40 to 49 pounds and so on. Later in the year a No. 1 is used in conjunction with the first two numbers to designate lamb as not being genuine spring but older, heavier animals down to sheep.

The meat industry has succeeded to a great extent in simplifying specifications and grades and has also taught the consumer to recognize brands. Nevertheless, no two beef animals are exactly alike and because some plants specify as many as 11 grades of steer beef, 11 grades of heifer beef, 9 grades of cow and 8 of stag and bull, plus 4 grades of heiferettes, the situation becomes complex and confusing to the uninitiated. Men in the trade admit they learn something new every day and no one reaches the "know it all" stage. Thus, it becomes important for hospital buyers to become acquainted with at least the primary fundamentals.

Federal specifications available for fish are those approved by the director of procurement for the use of all departments and establishments of the government. Section IV (part 5) of the Federal Standard Stock Catalogue lists applicable specifications as to species, types and grade of fish; frozen, salted or smoked fish, clams and oysters.

At the Fish Pier in Boston, a key distributing center for Atlantic fish, dealers usually specify three grades of fresh fish. The first is the fancy shore fish known as "Guinea Grade." For the duration of the war, it is unlikely that this quality will appear on the market because of government regulations barring enemy aliens from working on our shores. The majority of these fishermen plying this shore trade have not been naturalized.

The next grade is called "Shore Vessel" and this quality of fish is brought in by boats making short trips outside the Channel and Cape Cod, their range being 200 miles or less. The cheaper grade, better known as "Trawler," brings a lower price at the pier because these boats fish at the Western Banks, a distance of 300 or 400 miles, and these trips average approximately two weeks. Consequently, this seafood is not as fresh when it reaches the consumer. Nevertheless, the variance in quality between "Shore Vessel" and "Trawler" is slight; the price spread is approximately 1 cent per pound.

To increase your purchasing ability, learn brand names and the quality they represent; become familiar with U. S. specifications and personally select foods whenever possible. Gain the confidence and respect of the merchants you patronize by learning to talk their jargon and impressing upon them that you "know your onions."

Value received for money spent can only be governed by constant vigilance to adequate specifications, selection of proper grades, a spattering of common sense and continual sentry duty so that inferior substitutes do not pass.

FOOD FOR THOUGHT

• The extent to which volunteer help may be used in hospital dietary departments was the subject of discussion at the annual meeting of the New Jersey Dietetic Association held in Atlantic City in conjunction with the New Jersey Hospital Association. It was the consensus that the services of lay women might be enlisted in making and serving nourishments, doing paper work, making salads and serving in the cafeteria.

• Some years ago Mrs. Mary K. Bloetjes, executive dietitian, Hospital for Joint Diseases, New York City, distributed a form among the personnel on which each individual was requested to jot down his preferences. If any particular type of food was discovered to be disliked by the majority, it was omitted from the menu or served infrequently. The big point in favor of the plan, according to Mrs. Bloetjes, was that it made everyone work and share responsibility in catering to food tastes.

• Considerable research is being conducted on methods for dehydrating foods with particular attention devoted to milk, eggs, vegetables, fruits and soup mixes. In addition to the obvious savings in shipping tonnage and space, food in such form can be packaged in nonmetal containers, thus contributing to the conservation of tin plate. Substitution of dehydrated products for the natural or processed varieties presents problems for dietitians. Those interested in exploring its possibilities will find much helpful information in Bulletin No. 262 issued by the New York State Agriculture Experiment Station.

October Menus for the Small Hospital

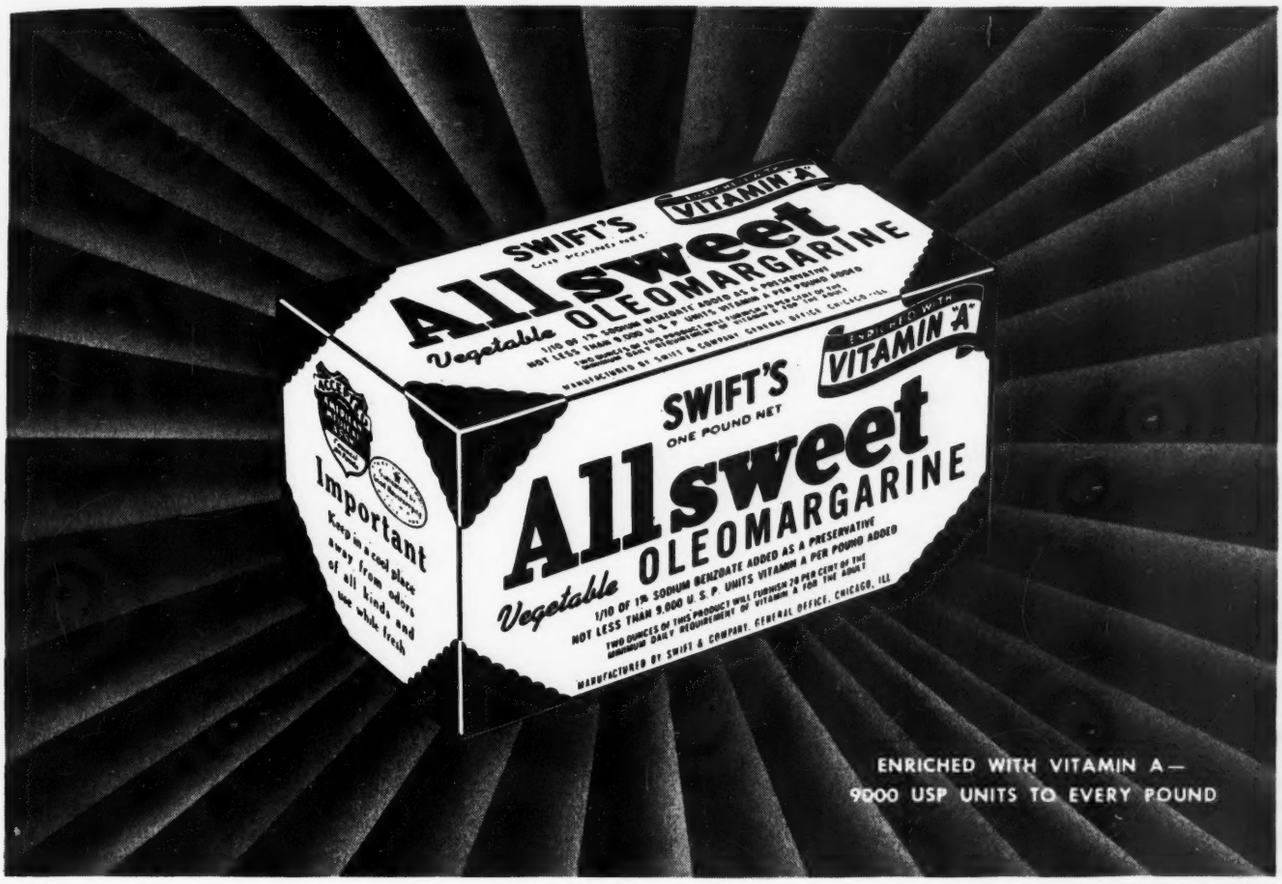
Anita A. Schaefer

Dietitian, Theda Clark Memorial Hospital, Neenah, Wis.

	Breakfast		Luncheon or Supper				
Day	Fruit	Main Dish	Soup	Main Dish	Potatoes or Substitute	Vegetable or Salad	Dessert
1.	Cantaloupe	Soft Boiled Eggs	Cream of Spinach	Cheese Fondue		Tomato Salad	Fruit Cup
2.	Oranges	French Toast	Cream of Pea	Tuna-Apple Salad	Potato Chips	Olives	Cookies
3.	Pineapple Juice	Cinnamon Toast	Cream of Tomato	Creamed Dried Beef on Toast	Baked Potato	Head Lettuce, Thousand Island Dressing	Baked Fresh Pears
4.	Orange Juice	Coffee Cake	Cream of Mushroom	Cold Cuts		Combination Vegetable Salad	Peach Shortcake
5.	Fresh Pears	Scrambled Eggs	Vegetable	Creamed Chicken in Rice Nests		Tomato Salad	Grapes
6.	Stewed Prunes	Bacon	Chicken	Vegetable Plate: Cauliflower, Carrots, Green Beans		Cottage Cheese	Sugar Cookies
7.	Bananas	Soft Boiled Eggs	Cream of Green Bean	Broiled Sweetbreads	Baked Potato	Head Lettuce, French Dressing	Cantaloupe
8.	Oranges	Preserves, Hard Rolls	Bouillon	Spaghetti Casserole		Stuffed Prune Salad	Muffins and Jam
9.	Stewed Apricots	French Toast	Vegetable	Welsh Rarebit		Tomato Salad	Sliced Peaches
10.	Grapes	Bacon	Cream of Spinach	Baked Stuffed Squash		Pear Salad	Coffee Cake
11.	Cantaloupe	Coffee Cake	Cream of Tomato	Creamed Asparagus on Toast		Chicken Salad	Layer Cake
12.	Orange Juice	Preserves, Hard Rolls	Cream of Green Bean	Scrambled Eggs and Ham		Carrot-Raisin Salad	Plums
13.	Bananas	Bacon	Egg Dumpling	Creamed Sweetbreads on Toast		Celery Cabbage, Bacon Dressing	Baked Fresh Pears
14.	Grapes	Sweet Rolls	Cream of Pea	Toasted Cheese Sandwiches		Celery, Pickles, Carrot Sticks	Cookies
15.	Stewed Prunes	French Toast	Cream of Spinach	Chop Suey	Unpolished Rice	Head Lettuce, French Dressing	Lemon Layer Cake
16.	Oranges	Soft Boiled Eggs	Cream of Mushroom	Vegetable Plate: Broccoli, Carrots, Asparagus		Pineapple and Cottage Cheese Salad	Cookies
17.	Tomato Juice	Preserves, Hard Rolls	Chicken Noodle	Creamed Dried Beef on Toast		Fruit Gelatin	Coffee Cake
18.	Fresh Pears	Preserves, Buttered Toast	Cream of Carrot	Cold Cuts and Cheese	Potato Chips	Stuffed Tomato Salad	Brownies
19.	Stewed Apricots	Scrambled Eggs	Cream of Corn	Chicken Salad	Potato Chips	Tomato Garnish, Olives	Fruit Gelatin with Whipped Cream
20.	Oranges	Bacon	Cream of Asparagus	Baked Stuffed Squash		Peach and Apple Salad	Biscuits and Honey
21.	Grapefruit Juice	Sweet Rolls	Cream of Green Bean	Cheese Fondue		Head Lettuce	Cantaloupe
22.	Apricot Juice	Soft Boiled Eggs	Beef Noodle	Salisbury Steak, Tomato Sauce		Fruit Salad	Peanut Butter Cookies
23.	Stewed Prunes	French Toast	Cream of Mushroom	Macaroni and Cheese		Combination Vegetable Salad	Sliced Peaches, Cookies
24.	Oranges	Hard Rolls	Cream of Tomato	Creamed Dried Beef on Toast	Baked Potato	Pear and Orange Salad	Coffee Cake
25.	Apple Juice	Soft Boiled Eggs	Cream of Spinach	Cubed Chicken in Potato Nests		Cranberry Gelatin	Chocolate Cake
26.	Grapes	Bacon	Chicken Vegetable	Spanish Omelet		Cabbage-Celery Salad	Plums
27.	Orange Juice	Sweet Rolls	Cream of Bean	Toasted Tomato, Lettuce and Bacon Sandwich		Olives, Celery	Cream Cake
28.	Fresh Pears	Scrambled Eggs	Consommé	Noodle Casserole		Vegetable Gelatin	Raspberries
29.	Grapefruit	Hard Rolls	Cream of Pea	Meat Croquettes, Tomato Sauce	Creamed Potatoes	Head Lettuce	Apple Muffins
30.	Stewed Peaches	Soft Boiled Eggs	Cream of Beet	Tuna Casserole	Baked Potato	Grape and Orange Salad	Spice Cake
31.	Oranges	Sweet Rolls	Egg Dumpling	Vegetable Plate: Sweet Potato, Green Beans, Broccoli		Cottage Cheese	Coffee Cake

Recipes will be supplied on request by The Modern Hospital, Chicago.

This "Guest-Quality" Margarine saves money *without sacrificing important nutrition—or flavor-goodness*



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Care for the Diabetic—Part II

ELLIOTT P. JOSLIN, M.D.

MEDICAL DIRECTOR, GEORGE F. BAKER CLINIC
NEW ENGLAND DEACONESS HOSPITAL, BOSTON

INSTRUCTION in the injection of insulin is given in part by the special teaching nurse and in part by having the patient administer his own insulin under direction of the insulin nurse on the ward.

At discharge the diet of the patient is usually slightly raised and the insulin reduced to offset possible reactions caused by increased activity at home. The patient is instructed to lower or raise insulin dosage by 2 or 4 units if on three successive days the urine tests indicate need for adjustment.

Surgery. The choice of anesthetic rests with the surgeon. However, spinal anesthesia has been the method of choice in all operations upon the legs and feet as well as for many pelvic operations. No tourniquets should be used upon the fingers or toes.

In surgical emergencies, operation is not postponed in an attempt to reduce the sugar of the blood or of the urine. The need for operation ranks first and the control of the diabetes, second. In such cases, if an immediate urine test shows a large amount of sugar or diacetic acid, a moderate dose of insulin is given before operation. If coma is present, then the usual coma treatment is given simultaneously.

Elective Operations. When a period of several days is available for preparation, the diabetes is brought under good control with a liberal diet, at least 100 and usually 150 grams of carbohydrate daily and plenty of fluid. Provision is made for supplementary vitamins or transfusions. On the day of operation from one half to two thirds of the usual dose of protamine zinc insulin is given before or immediately after operation and the dose of crystalline insulin postponed and administered according to tests of the urine obtained every four hours and in quantities as above cited. If an infusion of glucose has been given intravenously either before or after the infusion the dose of insulin is not based on the first urine specimen obtained after the infusion but on a second specimen obtained perhaps an hour later.

Catheterization is avoided except in urgent situations. Distention of bladder must be watched for, particularly in prolonged convalescence.

Emergencies. Hypoglycemia is evidenced by weakness, trembling, sweating, collapse, convulsions or mental changes. With patients using protamine zinc insulin, headache, nausea and vomiting may be the only symptoms. The subdued or intractable child and the argumentative adult may be hypoglycemic. When hypoglycemia is suspected, blood must always be taken for a determination of sugar content before treatment is given, although treatment need not be delayed until the report is received. A lump of sugar or from 50 to 100 cc. of orange juice or ginger ale is given by mouth every ten minutes until recovery.

If the patient does not improve promptly, and especially if unconsciousness is present, glucose is given intravenously at once. For such an emergency, a special box is maintained on the diabetic floor, equipped with sterile syringe and needle and a 20 cc. ampule of 50 per cent sterile, buffered solution of glucose. For prolonged hypoglycemia, a continuous infusion of 5 per cent glucose is advised.

Diabetic Coma. The gravity of diabetic coma increases with the age of the patient, the duration of the diabetes and the depth and duration of the coma before treatment is begun. For purposes of classification, a case is to be considered in the diabetic coma zone if the acidosis as measured by plasma CO_2 content is 20 volumes per cent or less. Diabetic coma is a medical emergency and demands the entire attention of a doctor and nurse and the constant availability of a laboratory technician until the patient is out of the coma zone.

A careful history, obtained from the family and friends, and a physical examination, thoroughly yet quickly made, are recorded on the special coma sheet, together with the results of all laboratory tests and all items of treatment, including insulin, fluids of all kinds given by oral, intravenous and subcutaneous routes, diet and medication. A line on the chart is arranged for each hour of the twenty-four hours.

For immediate determination of sugar, NPN and CO_2 content, 12 to 15 cc. of venous blood is drawn. For sugar and NPN determination, 5 cc. is placed in a bottle containing sodium fluoride; for plasma CO_2 content, 6 to 10 cc. is placed under oil in a tube containing potassium oxalate. Larger amounts of blood are necessary if determinations of other constituents, such as acetone and chloride, are desired.

Determinations of blood sugar and CO_2 are repeated about every two hours in severe cases until safety is established and every six hours for the first twenty-four hours after recovery from the coma zone. Capillary blood samples to save the veins are preferred as soon as CO_2 tests can be omitted.

Treatment should begin immediately as soon as the diagnosis, based upon history, physical examination and examination of the urine, has been made. When doubt exists, no insulin is given until reports regarding blood sugar and plasma CO_2 content have been made. If truly in doubt, intravenous glucose is used

Chemotherapy and Surgery

SINCE the introduction of the sulfonamides and the further discovery that local therapy was at times efficacious, there has been a host of papers reporting the topical use of sulfanilamide and sulfathiazole, introduced in pleural, pericardial, peritoneal and joint cavities, and on burned areas or cutaneous infections.

Recently much stress has been placed on the necessity of sterilizing the sulfonamide powder or crystals thus used.

Specific oral and parenteral chemotherapy with these drugs owes much of its clinical success to the relative ease with which effective concentration can be attained and maintained in the blood stream. The National Research Council's subcommittee on surgical infections has recommended the local application of sulfonamides as a light dusting to the wound surface, using not more than 1 gram for each 10 square inches of surface. Thorough cleansing of the wound and adequate debridement are stressed as essential. Local treatment generally should be supplemented by oral administration.

That the sulfonamides such as sulfanilamide, sulfadiazine and sulfathiazole are bacteriostatic is recognized. To what extent they neutralize bacterial exotoxins, affect wound healing and prevent growth of various bacteria in wounds still awaits final evaluation. Certain it is that the use of these compounds will never replace skilful surgery.

The Squibb Laboratories have been keenly interested in the sulfonamides and their various clinical applications. It will be our policy to provide special dosage forms as the need arises.

when action appears imperative and hypoglycemia probable. If the diagnosis of diabetic coma is absolutely definite, injections of insulin and salt solution are begun as soon as blood has been taken and without waiting for a report.

The patient is kept warm with blankets and with hot water bottles placed outside the blankets.

Gastric lavage and saline enema are used in all except extremely weakened or moribund patients.

Particularly if the desired response to treatment is not obtained or if fever is present, precipitating infection may be present and appropriate treatment, medical or surgical, must be instituted promptly.

Peripheral collapse (shock) is treated with intravenous fluids, ephedrine, caffeine sodium benzoate 0.5 grams, adrenalin and transfusion of whole blood or plasma.

Insulin. Remember that diabetic coma is primarily a state of insulin deficiency. Nothing will take the place of adequate amounts of insulin given promptly. The dose the first hour may do the work of two or three times as much insulin the second hour.

The initial dose of crystalline or regular insulin lies between 20 and 100 units, depending on the severity of the case. When peripheral collapse is present, insulin should be administered intravenously as well as subcutaneously with massage of the extremities.

Like doses should be repeated every half hour, usually for at least from three to five doses or until patient begins to improve. When urine or blood tests indicate falling blood sugar, the dose is reduced sharply and the interval between doses is increased gradually to four hours.

When urine tests are used as a guide for insulin administration, subsequent to the first few doses, the bladder must be emptied after each test. Catheterization is to be avoided, if possible, but when necessary an inlying catheter is used. A schedule appropriate for many cases follows:

If Benedict test is	Red	Orange	Yellow	Yellow Green	Green or Blue
Give clear insulin, units	24	20	16	12	0

If the urine becomes sugar free or nearly so, the interval of testing is increased gradually to four hours and the carbohydrate intake of 10 grams per hour is maintained by the oral or parenteral route until approximately 100 grams is reached.

Relapse into coma is prevented by cautious introduction of protamine zinc insulin when approaching recovery is evident. Blood sugar tests are continued every four hours for the first twenty-four hours after the plasma CO_2 is above 20 volumes per cent unless very obviously unnecessary.

Fluids and Food. Isotonic solution of sodium chloride both intravenously and subcutaneously should be given until the initial blood chemistry is reported. Glucose should not be added until the blood sugar approaches normal and is necessary then only if the patient cannot take carbohydrate by mouth.

The total parenteral fluid requirement in first twenty-four hours is usually, in all but mildest cases, from 2000 to 6000 cc., of which only one half is given intravenously. In presence of anuria, cannula is inserted into vein and constant intravenous saline infusion is allowed up to 10,000 cc. in twelve hours, provided gross edema or other signs of congestive heart failure are not present.

After the blood sugar begins to fall carbohydrate should be administered in some form orally or parenterally at an average rate of at least 100 grams during the first twelve hours and 50 grams the second twelve hours.

After gastric lavage, and when vomiting has ceased, liquids may be given orally in gradually increasing amounts up to 120 or 150 cc. per hour. Use water, broth, tea or coffee, ginger ale, fruit juice or gruels. Avoid cold liquids.

Treatment with alkalies is unnecessary and, even if not harmful in some patients, diverts attention from the essential factors: insulin, fluid and salt.

In the few days following recovery, a gradual return to a regular diet is accomplished.

Treatment according to specifications here given was without mortality for 61 successive cases of diabetic coma with CO_2 content of 20 volumes per cent or less at the George F. Baker Clinic during the period between Aug. 21, 1940 and July 6, 1942.

Pertinent Points on Conservation

J. S. Mordell, secretary of the pharmacy section of the American Hospital Association, in an interview with the Washington correspondent of The Modern Hospital, suggested pertinent measures of conservation in prescribing medicaments. Attention should be paid, he said, to quantities that fit the immediate needs of the patient.

"Half liter bottles of material should not be issued when 60 or 90 cc. bottles will suffice, nor should half kilogram ointment containers be used when 30 or 60 gram containers will be ample," he continued. "In connection with ointments, individuals should be reminded that the portion doing the work is what is on the skin not saturating the bandage. A 30 cc. dropper bottle contains, depending on the nature of the liquid, about 480 drops. A dosage of five drops three times a day would make this quantity last about a month. Since the average use is considerably less than a month and since deterioration might be involved in the excess, a smaller sized bottle should be used for the average case.

"Parenteral solution trays and similar units should be checked with a view to simplification and elimination of unnecessary items, such as superfluous hypodermic needles, rubber or metal materials. In this connection, the use of a central supply room is a potent means of efficient and economic control.

"In addition to the conservation of critical material, an important perspective to maintain in this whole picture is that conservation of currently noncritical material is a contribution to the war effort. It means conservation in the man power required to produce such material."

Drug Routine Improves Service

THE following instructions for ordering drugs and prescriptions were designed by the drug committee of Hamot Hospital, Hamot, Pa., to improve the service to patients, nurses and doctors.

ORDERING FLOOR DRUGS

1. Orders for all floor drugs and preparations routinely furnished to the nurses' stations are to be delivered to the pharmacy before 9 a.m.

2. Orders are to be made out on a special form. Alcohol and floor narcotics are to be ordered on this form. Other narcotics are to be ordered on a separate form. Requisitions for floor drugs will not be considered complete unless they bear the current date, the station for which the items are ordered and the signature of the supervisor.

3. Pills, tablets and capsules are to be ordered in units of 25 or multiples thereof, except in the case of narcotics, which will be supplied in units of 20, and in other cases as necessary exceptions may arise.

4. Items ordered by floors are charged to the floors to which they are sent. Therefore, borrowing or lending of drugs reflects to the disadvantage of the floor from which stocks are removed.

ORDERING SPECIAL DRUGS

1. Orders for special drugs for patients will be filled in the pharmacy between 9 a.m. and 4 p.m. daily except Sundays.

2. A form is supplied for special requisitions. The requisition will not be honored unless the following information is included: name of patient; room or ward; pay or free status; date, and signature of doctor, with full information regarding the item desired and the physician's narcotic registry number when necessary.

3. Special drugs left by patients must be returned promptly to the pharmacy. Under no circumstances may they be kept on the floors for dispensing to other patients. Negligence in this matter will be considered a serious offense.

4. Under no circumstances may drugs of any description be issued to employes or to any person without a written order signed by a doctor. Any individual desiring drugs without the written authorization of a doctor should be referred to his personal physician or to the emergency room.

ORDERING DRUGS AT NIGHT

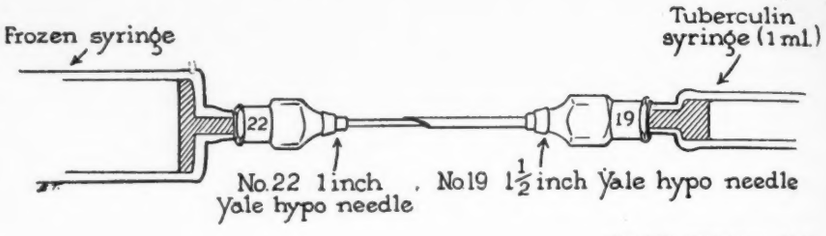
1. Only emergency medications will be supplied during the hours that the pharmacy is closed, *i.e.* nights from 5 p.m. to 9 a.m. and all day Sunday.

2. Special medications to be administered at night in accordance with doctors' orders are to be obtained from the pharmacy during the hours that the pharmacy is open.

3. Requisitions for emergency medications ordered after 5 p.m. must be authorized and handled by the night supervisor or the supervisor in charge. The supervisor must see that all necessary information requested on the form is properly and completely filled in and that the requisition is left either in the pharmacy or in the business office.

4. The hospital will not assume responsibility for any prescriptions not ordered by the supervisor in charge through the business office.

Rehabilitating "Frozen" Syringes



MILAN NOVAK, M.D.

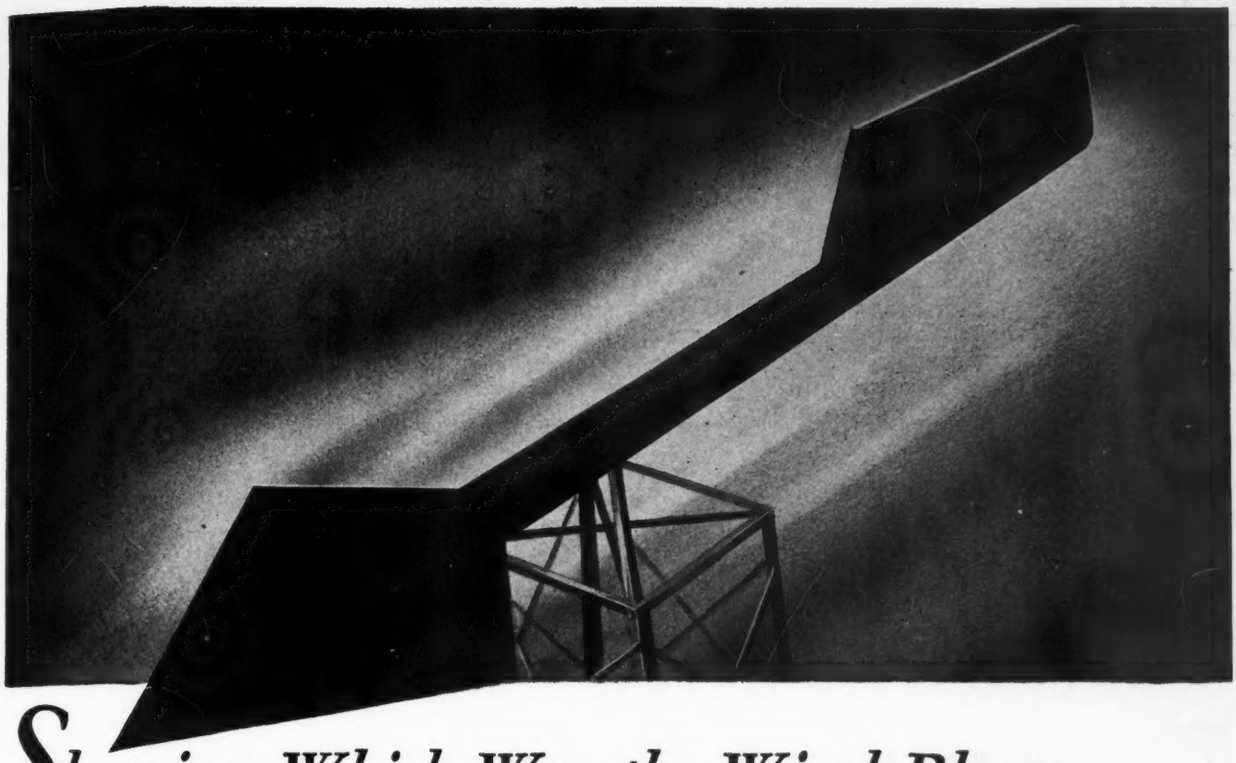
ONE of the common problems in hospitals and laboratories is the frequent plugging of glass syringes. Many of these are subsequently broken in frantic efforts by interns, technicians or nurses to remove the plunger by force and serious injury from broken glass occasionally takes place.

For many years we have used a simple method to loosen and remove "frozen" plungers. This procedure accomplishes the desired result without fail and involves no hazard that might lead to injury of the manipulator.

Although similar methods have been described in the literature, we feel that the simplicity of our method, together with the ready availability of the materials and absolute foolproof results obtainable, makes it superior to others. The accompanying drawing illustrates the method.

The essential device consists of two telescoped hypodermic needles. Two needles that make a tight connection when the smaller of the two is inserted into the larger one are selected. The connection may be soldered if desired but we have not found this necessary if two tightly fitting needles, such as the combination shown in the drawing, are employed. One end of this device is attached to the "frozen" syringe and the tip of a 1 ml. Yale tuberculin syringe filled with water is inserted into the opposite end. By applying pressure on the plunger of the tuberculin syringe a tremendous hydraulic pressure is created, which forces the barrel of the frozen syringe. It is necessary to use a tuberculin syringe with a smaller bore than that of the frozen syringe in order to obtain a ratio that will give a maximum hydraulic pressure. All air in the system must first be displaced by repeatedly filling the tuberculin syringe with water and forcing it into the space occupied by air.

This procedure will remove plungers even from syringes that have become dry and whose contents have crystallized. By this hydraulic method, water is forced into the area between the plunger and the wall of the barrel and after a short period the dried material is dissolved; the plunger then can be removed.



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ISO-IODEIKON* (Phentetiothalein Sodium N.N.R.)—This isomer of Iodeikon, developed by Dr. E. A. Graham and his associates in collaboration with Mallinckrodt research chemists, was first introduced by Mallinckrodt Chemical Works. This excellent X-ray medium permits the examination of the gallbladder and the measurement of the hepatic function from a single injection of the dye.

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NOTES AND ABSTRACTS

Conducted by Carl C. Pfeiffer, M.D., F. F. Yonkman, M.D.
Arnold J. Lehman, M.D., and Harold Chase, M.D.

Sympathomimetic Compounds in Bronchial Asthma and Hay Fever

The demonstration by Oliver and Schäfer in 1895 that extracts of the adrenal medulla would induce marked rises in blood pressure when intravenously injected initiated intensive research regarding the chemical structure of the substance injected and its mode of action. The active principle, epinephrine, was synthesized by Stoltz in 1904 and by Dakin in 1905.

Inasmuch as this substance may cause stimulation of some structures (as the heart and the smooth muscle of systemic arterioles) and inhibition of others (as the smooth muscle of the intestine and bronchioles), the concept of different receptor mechanisms in the various organs acted upon has been evolved. Thus, epinephrine may be represented as a "polyvalent" chemical agent whose various chemical groups act to a greater or less degree on some one or more of these receptor mechanisms.

Research in synthetic chemistry and pharmacology has led to the introduction into therapeutics of many sympathomimetic compounds with a fair degree of specificity for some one of these receptor mechanisms. All of these compounds possess a common chemical nucleus ⟨⟩-C-C-N but contain modifications both on the ring and on the alkyl side chain. Thus, epinephrine (3-4-dioxyphenyl-1-methylamino-2-ethanol-1) and neosynephrine (3-oxyphenyl-1-methylamino-2-ethanol-1) both cause a rise in blood pressure but neosynephrine differs from epinephrine in that it requires larger amounts of the material to produce the same rise in blood pressure, causes a more sustained pressure rise, has little central action and is not a consistently active broncho-dilating agent. Benzedrine (phenyl isopropyl amine) is a weak vasopressor agent but is an effective central stimulant.

Action on the Bronchial Musculature

• Epinephrine is the most active bronchodilator. Tainter and associates have pointed out the importance of the catechol group (3-4-dioxyphenyl) for this action. Arterenol (3-4 dioxyphenyl-1-amino-2-ethanol-1), differing from epinephrine only in that it contains no methyl group attached to the N-atom, is only slightly less effective than epinephrine as a bronchodilator in experiments where dogs were used as the experimental animal. Epinine (3-4-dioxyphenyl-1-methylamino-2-ethane) and 3-4-dioxyephedrine (3-4-dioxyphenyl-1-methylamino-2-propanol-1) are both active bronchodilators although they are somewhat less effective than epinephrine and arterenol. Ephedrine (phenyl-1-methylamino-2-propanol-1) was found to be only moderately effective and neosynephrine a poor bronchodilator.

Barlow and Frye of Cleveland have confirmed this in part. In a carefully controlled study of the action of epinephrine, ephedrine and atropine on a male medical student in whom asthmatic attacks could be induced by exercise (air hunger), they found epinephrine to be the most effective agent for the relief of the induced asthmatic attacks. Ephedrine was found to be mainly effective in the relief of mild attacks or as a preventive, whereas atropine was unsatisfactory for either acute or mild attacks.

Numerous reports from many clinics have shown that in acute attacks of bronchial asthma, epinephrine given either subcutaneously or intramuscularly

will (1) increase the absolute and relative value of the vital capacity, (2) decrease the midcapacity and residual air and (3) relieve the distress associated with difficult breathing. The disadvantages reported have been (1) the ineffectiveness of oral administration, (2) the danger of unfavorable side reactions, (3) the development of tolerance following repeated administration and (4) the frequent occurrence of restlessness, apprehension, headache and sometimes tremor following the period of administration. These disadvantages have led to intensive search for new compounds equally effective but longer acting and free from the unfavorable side reactions. Of these, ephedrine is most often used. This alkaloid is effective when taken orally and may be dispensed in the form of a tablet, capsule or in solution.

Epinephrine in Oil

• Less frequent need for medication and some reduction in the intensity of the side reactions can be obtained if the epinephrine gains access to the circulation in small amounts over a considerable period of time. Watery solutions, injected subcutaneously or intramuscularly, are rapidly absorbed.

Keeney and associates in Baltimore have prepared a uniform suspension of epinephrine in peanut oil by exposure to supersonic vibrations. By this means, this material is made into an extremely fine suspension in the oil and may be given either subcutaneously or intramuscularly without discomfort to the patient or injury to the tissues with which it comes in contact. These investigators have recently reported the results obtained from ten patients with chronic asthma treated with their suspension in oil.

They found 1.3 to 4 mgm. of epinephrine in oil injected subcutaneously gave relief from asthmatic symptoms for from eight to sixteen hours. Eleven patients given 1 to 3 mgm. of epinephrine in oil during acute paroxysms obtained relief for from nine to sixteen hours with an average duration of relief of twelve hours. The hazards of this form of therapy seem to be no greater than those resulting from the use of aqueous epinephrine solutions.

Inhalation of Epinephrine Solutions

• Although frequent reports of the use of epinephrine applied directly to the bronchial mucosa have appeared since 1910, this form of treatment in bronchial asthma did not receive serious consideration by clinicians in this country until 1935 when Graeser and Rowe of Oakland, Calif., reported several cases in which relief had been obtained by the inhalation of epinephrine. They recommended the use of a 1 per cent epinephrine solution dispersed as a fine spray and inhaled in this form by the patient.

Graeser, in a more recent report, states that concentration of from ½ to 2 per cent epinephrine may be used inasmuch as the sensitivity of different individuals varies somewhat. He reports that no relief was obtained by the inhalation of 10 per cent ephedrine solution or of a 5 per cent neosynephrine solution.

Treatment of Mucous Congestion

• A great deal of discomfort may result from the congestion of the nasal mucosa as found in coryza, hay fever and vasomotor rhinitis. Epinephrine solutions, particularly epinephrine in oil, have been used in these cases. Their usefulness, however, is limited by the short duration of action and by a subsequent period of after congestion of the mucous membranes. Ephedrine is largely free of these limiting disadvantages and has attained considerable popularity as a decongestant of nasal mucous membranes. Neosynephrine also is extensively employed in this connection and has been found to be remarkably effective. It is not irritating to the mucosa, is long acting and does not cause after congestion. Benzedrine, a volatile sympathomimetic compound, is used as a decongestant of the nasal membranes. This

substance is usually used as a 1 per cent solution of the base in oil or is applied from an inhaler.

Summary

• Pharmacological and clinical investigations have led to the use of various naturally occurring and synthetic compounds in the treatment of asthma. Of these, epinephrine and ephedrine are the most useful, although neither is free from objections.

Further research is needed to develop the ideal bronchodilator. From available information, it would seem that this compound would have the catechol nucleus of epinephrine and an alkyl side chain similar to that of ephedrine. The long duration of action of ephedrine appears to result from the greater stability of its alkyl group, this compound not being acted upon by the amine oxidase of the tissues. The bronchodilator should further be equally active upon repeated administration, should be stable in the alimentary tract and should be a relatively weak vasopressor agent.

Neosynephrine, benzedrine and ephedrine have gained considerable popularity as decongestants of the nasal mucous membranes. Neosynephrine has received much favorable attention because of its long action and freedom from irritation. Benzedrine (amphetamine) has the advantage in that it can be administered by means of an inhaler.—A. M. LANDS, PH.D.

CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

Allergy Reviewed

From time to time, lengthy articles of absorbing interest to the hospital administrator appear in the medical journals. In many instances these articles cannot be abstracted because the essential facts are so numerous.

Such an article is "Allergy, a Review of the Literature of 1941" by Francis M. Rackemann of Harvard Medical School, appearing in the *Archives of Internal Medicine* for January 1942.

Allergy is of great concern not only to the clinician but also to the administrator who must provide facilities for treatment of hospitalized cases. As a review article, this one is excellent; it should be read by every administrator so that he may be in a position to discuss the problem of allergy with his medical staff more intelligently.—E. M. BLUESTONE, M.D.

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Improved Oxygen Equipment

The introduction of the B.L.B. mask (developed in the Mayo Clinic in 1938) provided a simple and efficient apparatus for wider testing and use of oxygen in various therapeutic applications. This is the contention of S. L. Cowan and J. V. Mitchell in *British Medical Journal* for Jan. 24, 1942.

A modification of this equipment was used by anesthetists of the University of Oxford, England. The principle is that by means of an air injector, such as is used in the common laboratory Bunsen burner, oxygen is diluted with air to a determined extent and the resultant mixture flows continuously into a reservoir bag, whence it is drawn as required through an inspiratory valve into a face mask. The mask is provided with a second nonreturn valve, which directs the expired mixture into the room. Apparatus on the injector principle can be used for making mixtures of other compounds besides oxygen and air.

The percentage composition of the oxygen-air mixture inspired by the patient can be adjusted instantaneously to any one of a number of fixed figures. Partial rebreathing, which allows only a negligible economy of oxygen at the cost of a significant amount of carbon dioxide inspired, is eliminated, with the result that the resistance offered to res-

piration is much reduced. Diagrams and details of the apparatus are given. —Newman M. Biller.

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Surgery Progresses

The American, the British and the German surgeon differ in their general attitude toward surgery, states Dr. Evarts A. Graham in a historical review in *Surgery, Gynecology and Obsterics,* Feb. 16, 1942. The British surgeon is a master clinician, diagnostician and technician. He excels in anatomy. We Americans have reduced the emphasis on anatomy and pathology and have been lured by physiology and biochemistry. The American Board of Surgery has discovered that a generation of surgeons has grown up ignorant of anatomy or pathology. These men, nevertheless, are good surgeons and are doing good work.

The spirit of research struck this country with terrific vigor. It was the ambition of every young surgeon to make some great discovery in the laboratory and to break out into print with it.

As a result, a great deal of research has been done but in most instances only small stones have been added to our edifice. We have affected other countries with this enthusiasm. Never before in the history of the world has there been anything remotely approaching the flood of scientific discoveries which has occurred in the last twenty years. The withering hand of Nazism is retarding this wave of progress.

The influence of the American College of Surgeons has improved the quality of surgical practice; through its journals and its meetings, surgeons have exchanged ideas. The American thirst for investigation in surgery removes it from the realism of mere craftmanship.

Our training program should not be interfered with by the great needs of the Army and Navy. Yet, these two agencies must be supplied with medical personnel. We must hold fast to the resident system despite the specter of hard times. Above all, we must remember that the practice of surgery is based on humanitarian principles.—H. H. Livingston, M.D.

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"A Doctor's Dilemma"

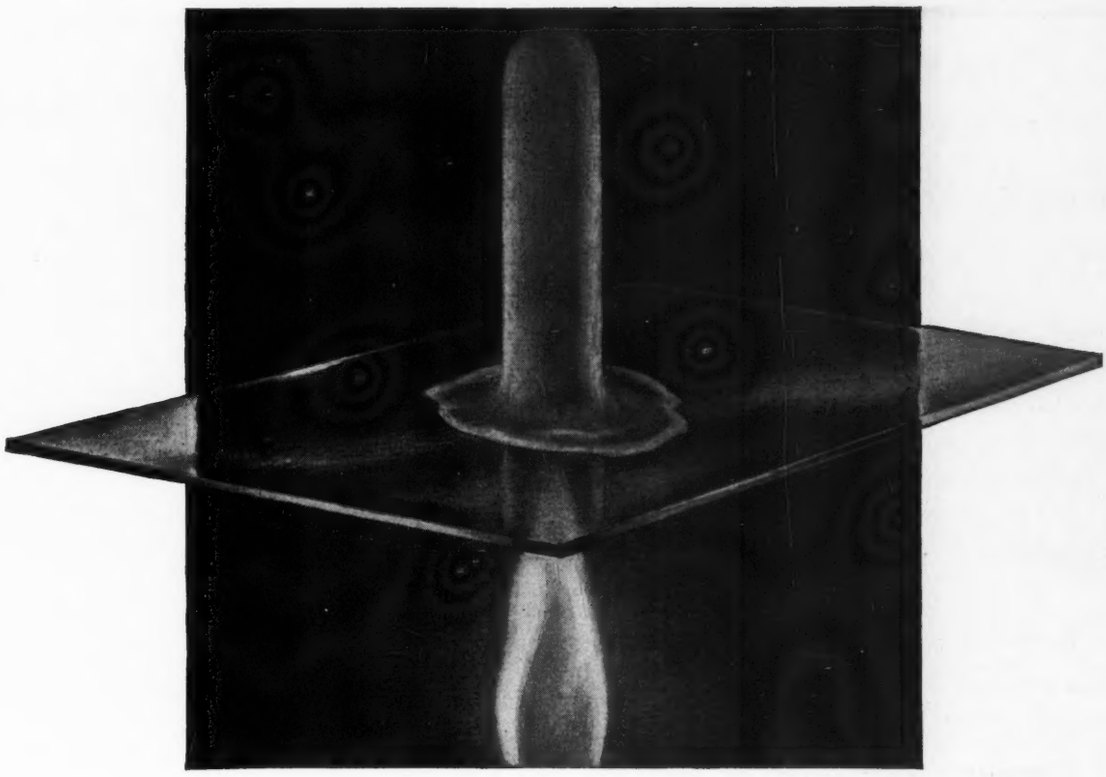
In the *Journal of Urology* for November 1941, according to the *British Medical Journal,* March 7, 1942, Dr. Elmer Belt of Los Angeles describes a dilemma that may face other medical men.

Doctor Belt operated on a patient in whom he had made a correct diagnosis of carcinoma of the prostate. He informed the family of his diagnosis, and the patient's daughter asked him to conceal it from her father, in view of the fact that the mother had already died of cancer of the breast; she felt the father would be too depressed by the news to stand it.

The patient was operated on successfully and later discovered what the diagnosis was. Thereupon he filed a suit against Doctor Belt for $113,500 for hiding the diagnosis from him, stating that if he had known the true facts he would never have entered into certain financial commitments. He was aware that the daughter had taken a part in concealing the information from him.

The medical defense agencies which were preparing to defend Doctor Belt pointed out that he might well be held responsible in court and that in future he ought always to get a responsible member of the family to sign a statement to the effect that the diagnosis should be withheld from the patient.

The outcome is best given in Doctor Belt's words: "I cannot tell you the answer to the problem because the other day, just before I left Los Angeles, we held a celebration in our office, the first time we ever held a celebration over a patient's death. The man died just as the suit was about to come to trial."



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News in Review

New Jersey Starts Medical-Surgical Plan for Pay Roll Deduction Groups

A nonprofit medical-surgical plan has been formed in New Jersey to operate through the enrollment facilities of the Hospital Service Plan of New Jersey and to be controlled by a board of trustees nominated by the Medical Society of New Jersey, according to an announcement last month by J. Albert Durgom, executive director of the hospital plan.

The plan is open only to pay roll deduction groups which are also members of the hospital plan and monthly premiums are 75 cents for individuals and $2 for families. For these fees the subscriber and his family members receive all necessary surgical services from participating physicians so long as they occupy semiprivate hospital accommodations and all necessary medical services in hospitals up to a maximum of 21 days in any contract year. If the patient elects private room service or selects a nonparticipating hospital or physician, cash payments according to a fee schedule are paid to the patient who must pay the difference himself.

Emergency surgical services in the out-patient department of approved hospitals are also included under the plan, each such service being counted as one day of bed occupancy. Maternity is covered under family contracts only and only for births that normally would occur at least eleven months after the effective date of the contract. Tonsils and adenoid cases are covered after two months, except that preexisting cases must wait eleven months.

Subscribers ceasing to be members of eligible groups can continue protection with annual payments of $12 or $28 for individuals or families and proportionately higher rates for semiannual and quarterly payments.

While enrollment, accounting and billing will be handled by the Hospital Service Plan of New Jersey, matters relating to professional services, patient-physician relationship, the payments for physicians' services and similar administrative details will be performed by the administrative personnel of Medical-Surgical Plan, under the direction of Dr. Norman M. Scott, executive vice president and medical director.

Physicians will be compensated for the complete service rendered semiprivate patients on a unit system, with the value of the unit determined in accordance with the amount of money available and the number of units of service rendered. For private patients the schedule of benefits provides $5 for the initial hospital visit and $3 for subsequent visits (limited to one a day). For specified surgical services overall flat rates are provided without regard to the number of visits. For example, any operation involving incision completely through the abdominal wall, except gynecologic and obstetric operations, is paid for at $100.

The Medical-Surgical Plan will not operate in any county until 51 per cent of the physicians of the county become participating members and the plan is approved by the county medical society. On July 1 the plan was ready for business in Bergen, Camden, Essex, Hudson, Mercer, Morris, Passaic and Warren counties.

The new plan will be offered first to the larger industries engaged in war production. At present more than 2000 organizations are enrolled in the hospital plan with 384,000 participants, making it the ninth largest plan in the country. With this new coverage the New Jersey plan will probably step up its rate of growth.

Medical Administrative Corps Officers to Replace Army M.D.s

WASHINGTON, D. C.—The War Department announces as part of a comprehensive plan to fill the need for some 20,000 additional doctors by the end of 1942 the replacing of Army Medical Corps officers now engaged in administrative duties by officers of the Medical Administrative Corps.

The latter officers are drawn from the enlisted ranks of the Medical Corps, many of them noncommissioned officers with years of experience in administrative operation of hospitals. Civilians above the age of 30 who are qualified in hospital administration by training and experience may be commissioned in the Medical Administrative Corps.

Seeks Substitute Metal for Sterilizers

WASHINGTON, D. C.—Recognizing the great need for some type of sterilizer to replace those worn out, the War Production Board is studying the situation to see if substitutes can be found for the nonferrous metals now used.

Hospitals Get Grants for Building Blood and Plasma Banks

Eighty-eight hospitals in vulnerable areas had, up to August 1, received grants to assist them in establishing reserves of blood and plasma for treatment of civilian casualties in case of enemy attack.

Many of the hospitals assisted are in the Eastern Seaboard states, predominantly Massachusetts, New Jersey and New York. Others are in Alabama, Connecticut, Florida, Louisiana, Maine, Maryland, North Carolina, Pennsylvania, Rhode Island, Texas, Virginia and West Virginia. On the West Coast, California and Washington hospitals have received grants.

New funds appropriated as of July 1 are subject to certain revised regulations governing their allocation. The geographical limitation—assistance only to hospitals located not more than 300 miles from ocean or Gulf Coast—was removed to permit a limited number of hospitals in inland target areas to participate. Hospitals in Cleveland, Chicago and other communities along the Great Lakes have thus received grants.

New conditions for obtaining grants follow. No competitive publicity campaigns for donor procurement shall be conducted within 75 miles of a Red Cross bleeding center procuring blood for the military service. In such hospitals a six month period instead of three is allowed for building the required plasma reserve, one unit of plasma per bed. Plasma may be used for current needs of the hospital in the treatment of its regular patients, provided the plasma reserve is not allowed to fall below the stated minimum.

If the reserve is depleted because of a large number of casualties, a reasonable time is allowed to rebuild the reserve to meet the requirements and additional aid is provided. The same concession will be made for approved hospitals which have not received grants but which furnish other hospitals with plasma prepared locally for the treatment of casualties caused by enemy action.

Samples of plasma must be submitted to the National Institute of Health for sterility testing as required by authorized representatives of the Public Health Service. Hospitals must keep clincal records of all cases receiving blood or plasma transfusions and report promptly any untoward experiences encountered in the use of plasma.

Million Volt Machines Out

At an industrial advisory committee meeting, it was decided by W.P.B. that million volt x-ray machines may no longer be manufactured.

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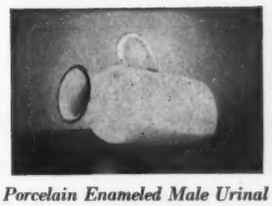

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How to Obtain Maintenance and Repair Materials and Service

EVA ADAMS CROSS
Washington Representative, The MODERN HOSPITAL

In a recent letter addressed to a hospital administrator, W.P.B. outlined the proper procedure for an institution to take in obtaining maintenance and repair materials and service. In order to keep existing equipment in operating condition and particularly equipment essential for public health, the War Production Board makes special provisions to facilitate acquisition of materials.

It is not necessary, it is pointed out, to file individual application for priority assistance each time a purchase of repair supplies has to be made.

"For materials such as steel, copper, brass, et cetera," the letter states, "and finished parts such as valves, pipes and cables, it is advisable that you establish yourself with some regular distributor or jobber, talk over with him your anticipated requirements for these materials and encourage his representative to visit your institution to review your past requirements and inspect existing equipment. Then, as necessity arises, you will be able to requisition from him the minimum quantities essential for the proper maintenance and repair of the equipment in your institution.

"He, in turn, is allowed to deliver these materials, in every case the least critical materials which are serviceable, and replace his inventory by filing an application on PD-1-X, stating thereon the conditions under which he disposed of his stock to you.

"In the case of repair services involving motor rewinding, surgical instrument repairs, laundry equipment repairs and the like, the repair shop will file application on PD-25-A for priority assistance covering the current or next calendar quarter. Such applications are to be sent to the Services Branch, War Production Board, Railroad Retirement Building, Washington, D. C. The applications will be so rated as to provide sufficient assistance for the repair shop to replace its inventory of materials and small tools.

"If you follow the procedures outlined above, and a distributor or repair shop refuses to make necessary deliveries for essential repair, we shall appreciate it if you send the refusal in writing to this office where appropriate action will be taken." Hospitals should address communications to the Bureau of Governmental Requirements, W.P.B.

Courses in Chemical Warfare Offered in Target Areas

WASHINGTON, D. C.—Physicians in all vulnerable areas of the United States are being given the opportunity to take extension courses in the medical aspects of chemical warfare. These courses are given under the auspices of the Office of Civilian Defense with the cooperation of medical schools and other institutions.

Among the schools offering such courses are the University of Cincinnati College of Medicine and Massachusetts Institute of Technology. In June similar extension courses of several days each were presented in Palo Alto and Los Angeles and gas seminars were held in San Diego, Portland and Seattle under the direction of Dr. Walter L. Mould, medical gas officer, Office of Civilian Defense. The nine medical schools in New York State have initiated a series of six hour extension courses or institutes for physicians in their vicinities.

As part of its program, the Office of Civilian Defense recently recommended the appointment of a senior gas officer to the staff of the commander of the Citizens' Defense Corps. Several of those who attended the three day course at the University of Cincinnati for senior gas officers had already been appointed as state gas consultants.

Gifts Down, Bequests Up

In the face of war-time emergency appeals, gifts to health agencies declined 33 per cent during the first six months of 1942 over the same period in 1941, the John Price Jones Corporation reports. Counterbalancing somewhat the decline in gifts to hospitals and other health agencies were substantially increased bequests, a rise of 170 per cent. Gifts for the first half of 1942 totaled $1,867,187 and bequests, $5,056,976.

MacEachern Heads Committee on Medical Staff Manpower

WASHINGTON, D. C.—Dr. Malcolm T. MacEachern, associate director of the American College of Surgeons, has been appointed chairman of a committee on hospitals of the Procurement and Assignment Service, War Manpower Commission, by Paul V. McNutt, chairman of W.M.C. The other members of the committee are Dr. Basil C. MacLean, president of the A.H.A., Dr. Lucius R. Wilson, president of the American College of Hospital Administrators, and Dr. Benjamin W. Black and Dr. Claude W. Munger, both past-presidents of the A.H.A. The committee will be concerned primarily with the hospitals' needs for interns, residents and staff.

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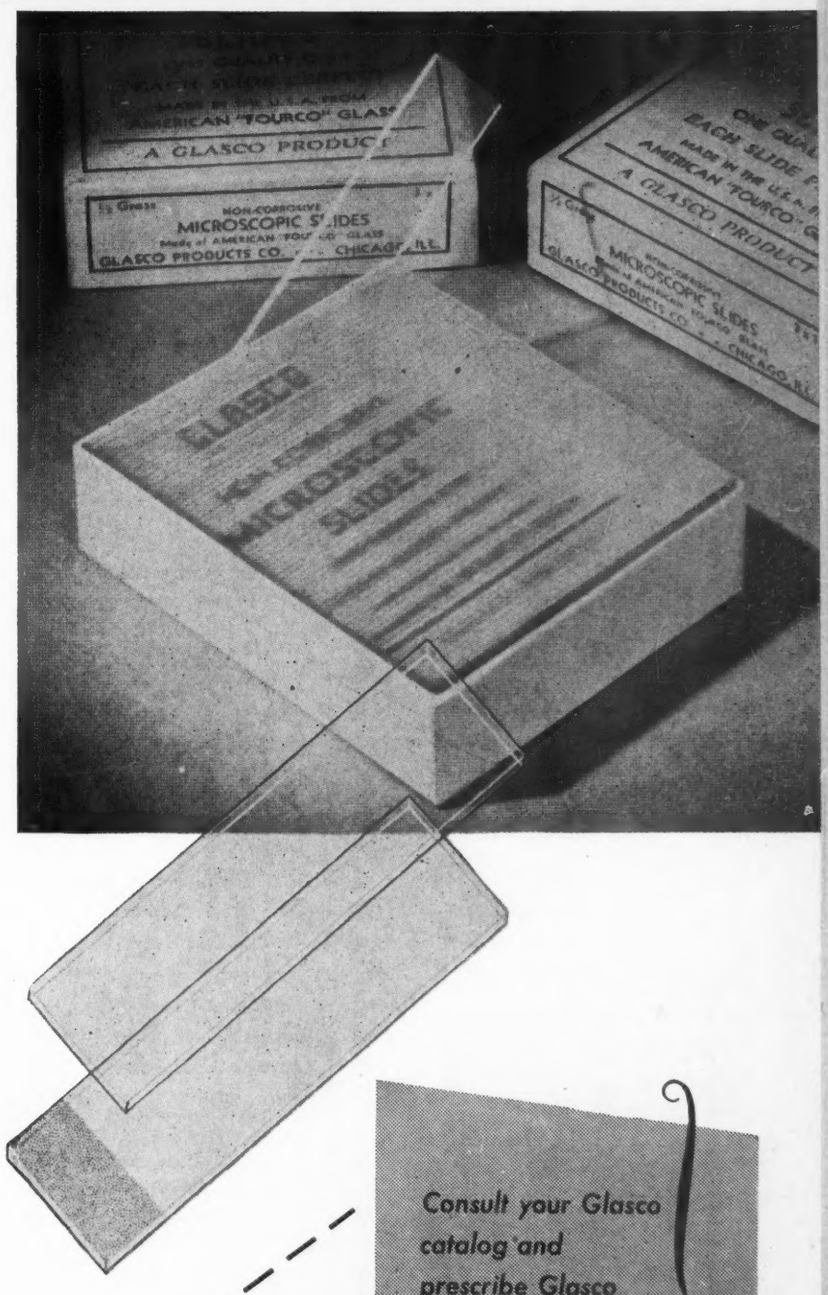

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Target Areas Will Train Nurses' Aides in Some "Unapproved" Hospitals

WASHINGTON, D. C.—A memorandum on August 5 from the chief medical officer of the Office of Civilian Defense to regional medical officers provides means for the designation of additional hospitals for the training of nurses' aides.

In view of the need for these aides in communities in target areas where there are no hospitals on the approved lists, the Medical Division of the O.C.D. and the Red Cross Nursing Service have agreed to supplement their original instructional letter. A conference in each state with the state hospital association, the state board of nurse examiners, the state chief of Emergency Medical Service and his nurse deputy and a nursing consultant from the area office of the American Red Cross will be arranged to determine which hospitals may be approved.

This conference will draw up a list classifying hospitals for the training of nurses' aides in two groups: those hospitals approved by the American College of Surgeons and registered by the American Medical Association, and those hospitals not so approved and registered but which, in the opinion of the various state agencies, should be approved for nurses' aide training in view of the present war emergency.

Hospitals Excepted From New Plumbing and Heating Order

WASHINGTON, D. C.—In the two amendments issued August 11, to Limitation Order L-79 covering certain plumbing, heating and cooking equipment, hospitals are still favored.

The first amendment includes in the terms of the order cooking and baking equipment using coal, oil or gas. Previously, only those types of cooking or baking equipment connected to gas or steam systems were covered.

The other amendment includes the following gas-burning heating equipment in the terms of the order: steam and hot water heating boilers, warm air furnaces, floor furnaces, unit heaters, conversion burners and gas steam radiators.

Order L-79 provides that no person shall sell or deliver any equipment covered by the order. Among the exceptions are items specifically designed for hospitals or for surgical purposes.

Two Hospital Units Called Up

U. S. Army General Hospitals No. 3 and 17 have been ordered into service. No. 3 is the Mount Sinai Hospital unit of New York City and No. 17 is the Harper Hospital unit of Detroit.

Here's Promising Substitute for Rubber Sheeting; at Work on Others

EVA ADAMS CROSS
Washington Representative, The MODERN HOSPITAL

Hospitals should be cheered by the news coming from the Technical Section of the Rubber Division, W.P.B., in spite of the announcement on August 10 that an amendment to Order M-15-b-1 prohibits the use of rubber in hospital sheeting.

Robert Dabney of the Technical Section greets the anxious visitor with the air of a man with good news to impart. "What, no rubber for hospital sheeting?" the visitor wants to know.

Mr. Dabney places in the visitor's hands two samples. "Select the piece you consider better," says the technical expert. Whereupon the visitor selects the lighter and apparently better piece. "That," Mr. Dabney points out triumphantly, "is not rubber at all, but a rubber substitute—a vinyl resin coated fabric, stronger, lighter, not subject to injury from alcohol or oil or grease of any sort."

Mr. Dabney predicts that when the war is over and we have all the rubber we want the substitute sheeting will be preferred. It will be on the market soon.

"What we need most," Mr. Dabney went on to say, "is cooperation from the public and from those in the hospital and other specialized fields. When we make modifications in a nursing nipple, for instance, it is not an arbitrary procedure but a plan carefully worked out under the advice of specialists in the baby field and it saves tons of rubber for vital war purposes."

Another rubber substitute that has proved its usefulness is polyvinl-butyral hose developed by several companies at the request of O.C.D. to take the place of rubber hose. So satisfactory is it that the military authorities have now requisitioned the entire supply to be used in waterproof garments and containers, pontoon boats and flotation bladders.

"Every possible source is being explored to develop another satisfactory stirrup pump hose," said James M. Landis, director of O.C.D. "If the Army and Navy require this material for military purposes, then obviously it is up to the civilian to step aside. . . . We are exerting the utmost effort to find ways to meet civilian needs . . . without interfering with military demands."

Standardization Conference Transferred to Cleveland

Cleveland and its Public Auditorium will be the scene of the 1942 clinical congress of the American College of Surgeons, originally scheduled for the Stevens Hotel, Chicago, which has been taken over by the U. S. Army Air Corps. The dates of the concurrent hospital standardization conference are November 17 to 20.

The three surgeon generals will address the conference, along with Col. George Baehr, O.C.D.; Dr. Frank H. Lahey of the Procurement and Assignment Service, and Dr. Irvin Abell of the Federal Security Agency. A large technical exhibition will be held as usual.

Urges Furniture From Cheaper Lumber; Situation Grows Serious

WASHINGTON, D. C.—W. A. Adams, chief of the War Production Board's furniture branch, announced August 13 that the wood furniture industry can help in alleviating shortages of many civilian products normally made of metal. High quality lumbers must be used for military purposes but lower grade wood may be used for the making of lockers, shelving, ice boxes, wash tubs, shipping containers, pails for home and civilian defense use, stirrup pumps for incendiary bomb protection and lamps.

Because of increased demands for lumber as a substitute material for critical metals and because of a shortage of labor, the lumber situation has recently grown more serious. A temporary freeze order (L-121) on construction lumber has been in effect for some weeks. A permanent order is scheduled to establish a system of rigid control.

It is estimated that over-all lumber requirements this year for military war housing and essential civilian needs will be approximately 38,000,000,000 board feet, or 6,000,000,000 board feet more than estimated production.

Convention Canceled; Board Meets

Because hotel and other space in St. Joseph, Mo., has been taken over for military purpose, the Missouri State Nurses' Association has canceled its annual convention. Instead, the board of directors will meet on Friday evening, October 23, in St. Louis and an all-day business meeting will be held Saturday.

Now Percy L. Jones Hospital

The former Battle Creek Sanitarium, Battle Creek, Mich., has become the Percy L. Jones General Hospital for war casualties, having been purchased by the Army for $2,251,000. It is named in memory of the late Col. Percy L. Jones, who was superintendent of Hamot Hospital, Erie, Pa.

W.P.B. May Amend Iron and Steel Order to Advantage of Hospital Equipment

A liberalization of the W.P.B. restrictions on the use of iron and steel for steel surgical furniture appeared to be in the making as this issue went to press. While final action had not yet been taken, a committee representing the manufacturers of steel surgical furniture had conferred at length with appropriate government officials.

Barring unforseen changes, it seemed reasonable to predict that four amendments would soon be ordered by W.P.B. in the iron and steel conservation order, M-126, to allow the continued manufacture of: (1) bassinets (confined to frame and basket only; no cabinet types); (2) bed cradles; (3) linen hampers and (4) solution and irrigator stands.

It was also suggested to the government representatives that the term "operating room" should be defined as "a room where are performed surgical procedures of any character."

There are some other items on the prohibited list about which there is still serious question, namely, arm immersion stands, blanket warming cabinets, dish trucks (especially the frames), dressing stands, orthopedic and fracture carts, supply and treatment cabinets, adjustable examining tables and utensil racks.

Priorities Regulation No. 12, which became available last month, provides for re-rating procedures when it is found that existing priority ratings are too low. We now seem to be engaged in a priority inflation and specific ratings are steadily depreciating in effectiveness. An A-1-a rating is now required for iron and steel and Everett Jones stated last month that dire need must be proved to get this rating.

There seems to be some confusion over the application of Priorities Regulation No. 10 to hospitals. This regulation provides that all purchase orders placed after June 30 must bear the appropriate allocation classification symbol and purchaser's symbol except "retail purchases, purchases by retailers and purchases by distributors for resale to retailers." Under "12.20—Health equipment and supplies including personal care" occurs the statement that "this symbol should be used by companies engaged in such operations as . . . the manufacture of abdominal supports, etc."

From information in the order and statements by hospital dealers it is apparent that hospitals themselves do not need to attach the symbols but these can be added by the dealers or manufacturers.

"Neither the allocation classification symbols nor the purchasers' symbol," states the order, "are intended to indicate order of importance."

Newly Commissioned State Civilian Defense Officials

WASHINGTON, D. C.—Recent commissions in the U. S. Public Health Service granted to Civilian Defense medical officials in vulnerable states and the District of Columbia include:

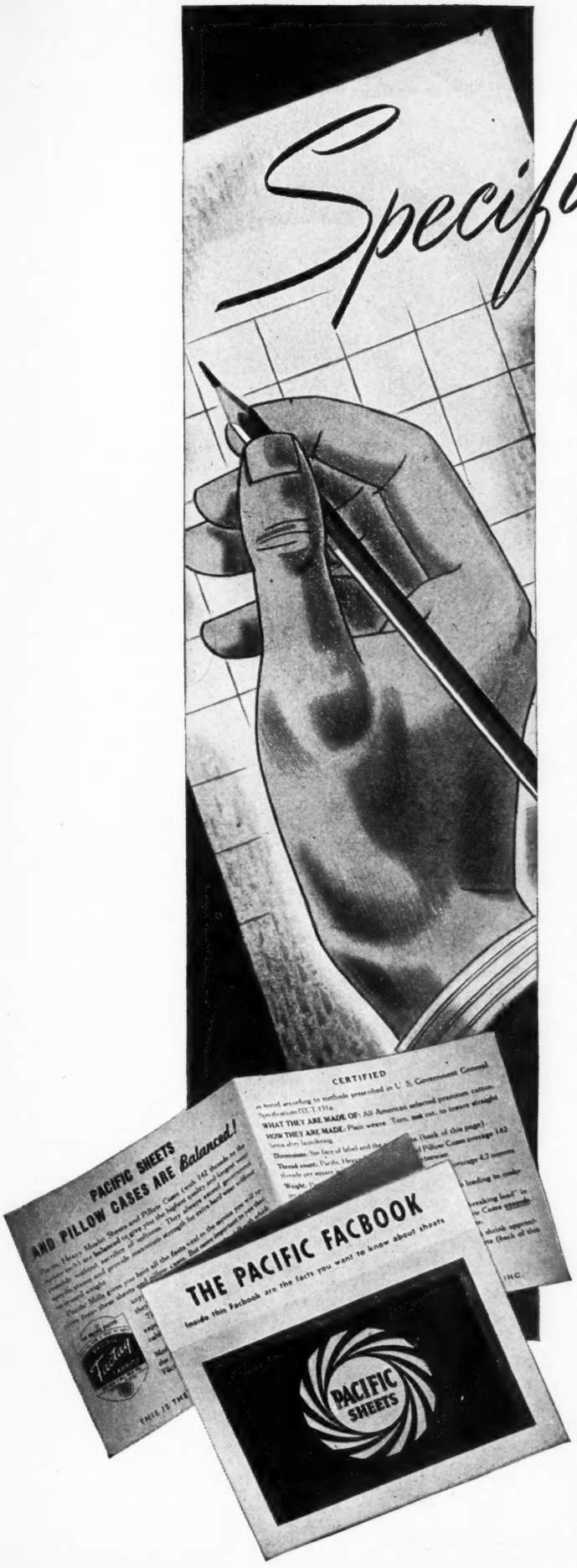
Northern California: Dr. Morton R. Gibbons Sr., San Francisco, deputy state chief of Emergency Medical Service.

Louisiana: Dr. Eugene H. Countiss, New Orleans, state chief of Emergency Medical Service.

New York: Dr. John J. Bourke, Albany, state chief of Emergency Medical Service.

Texas: Dr. Fred P. Helm, Austin, formerly of Topeka, Kan., deputy state chief of Emergency Medical Service.

Dr. James H. Stephenson, medical superintendent of Jefferson Davis Hospital, Houston, Tex., has been commissioned and appointed hospital officer for the Eighth Civilian Defense Region (Arkansas, Louisiana, New Mexico, Oklahoma and Texas).



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This you can bank on: Pacific Balanced Sheets are made to the same high standards as in pre-war days. Their qualities are still skilfully balanced. Strength, whiteness, softness, smoothness, firmness—all are present in equal degree, none slighted to enhance another.

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PACIFIC *Balanced* SHEETS

Reference List of Official Orders

(Issued from July 15 to August 15)

WASHINGTON, D. C.—Many War Production Board orders of importance to hospitals were issued during the past month. For ready reference by administrators and purchasing agents they are tabulated alphabetically as follows:

Priority Orders

Beef and Veal.—State and municipal institutions may purchase these products at price ceilings established by their own purchases during the thirty days following March 15, 1942, or at the applicable ceiling price of the seller under M.P.R. 169.

Coffee, Tea.—Orders M-135-c and M-111-d, July 30, effective increases ranging from 10 per cent to 100 per cent in coffee and tea quotas.

Construction.—Amendment 3, issued July 23, to Conservation Order L-41 liberalizes in several important respects the strict control over nonessential construction; specifically it permits an owner to begin construction of institutional structures damaged or destroyed after July 23, provided immediate restoration is necessary to protect public health or safety.

Copper.—Use of copper and copper-base alloy in building construction except wiring was forbidden by Conservation Order M-9-c-4, issued July 22. But 25 pounds or less may be used to repair a building where the metal replaces building material (pipe, tubing, etc.) previously installed.

Elevators.—Because adequate priorities assistance is available under the Production Requirements Plan, Orders P-72, as amended, and P-91 have been revoked. These orders extended preference ratings for materials going into the production, repair and maintenance of elevators, escalators and dumb-waiters.

Amendment 1, issued July 31, to Order L-89 excepts hand elevators from provisions of Order L-89 and makes it clear that electro-hydraulic elevators are excepted from limitations of the order.

Inventories.—To make it simpler for distributors to operate under Suppliers' Inventory Limitation Order L-63, that order was reissued August 13 in a form that brings together its various amendments and exemptions.

Iron and Steel.—Order L-49, as amended August 4, stops the production of innerspring mattresses by September 1 and of studio couches, sofa beds and lounges in November if such products contain iron or steel. Hospitals and sanitariums are exempt from the restrictions of this order.

Mercury.—Amendments, August 5, to the mercury Conservation Order M-78 make several additions both to the permitted and to the prohibited uses of mercury.

Metal Office Furniture.—Order L-13-a, as amended August 5, prohibits manufacturers of metal office furniture from working on any order, including armed services, unless the order has specific W.P.B. authorization.

Plumbing, Cooking Equipment.—Amendments 1 and 2 to Order L-79 as amended, covering certain plumbing, heating and cooking equipment, and Amendment 1 to Order P-84, providing for preference rating assistance in connection with repair and maintenance of cooking and baking equipment, were issued August 11. Exceptions to the order are items designed specifically for hospitals, and for surgical purposes.

Pyridine.—Order M-185, issued July 29, places the production and distribution of pyridine, used in the manufacture of sulfa drugs, under complete allocation control.

Rubber.—Amendments 9 and 10, issued July 21, to Order M-15-b-1 further conserve rubber by placing stringent specifications on a long list of civilian products. Rubber sheeting for hospitals was permitted under the original order but specifications were made as to how much rubber was permitted in the sheeting.

Amendment 13, issued Aug. 10, to Order M-15-b-1 prohibited the use of rubber in a comprehensive listing of products, among them hospital sheeting. A satisfactory substitute has been found for rubber sheeting.

Rubber Thread.—Order M-124 was amended July 30 to restrict the use of rubber thread in foundation garments to those designated as surgical garments.

Amendment 4, issued July 31, to Order M-124 makes the Defense Supplies Corporation the sole purchasing agent for the rubber yarn, latex yarn and elastic thread previously frozen. The amendment adds industrial goggles and webbing for artificial limbs to the list of essential health items in which the use of previously fabricated rubber thread, size 61 or finer, is permitted.

Sugar.—Increases in sugar allotments of institutional users previously announced for July and August will be extended to September and October, O.P.A. stated on August 3.

Surgical Textiles.—Surgical textiles were excluded from the scope of Maximum Price Regulation No. 157 by amendment 4 issued by O.P.A. on July 23. These supplies are now under the general maximum price regulation.

Tannic Acid.—Order M-204 establishes complete control of tannic acid U.S.P. and of its source, "nutgalls."

Typewriters.—Manufacture of typewriters will be stopped completely on October 31, except for a relatively small number for governmental agencies, according to an amendment of August 4 to Order L-54-a. All new typewriters manufactured are reserved for the government.

Wood Furniture.—Limitation Order L-135, effective November 1, prohibits the production of wood upholstered furniture containing any iron or steel other than joining hardware.

BATAAN

America's Priceless Ingredient...

The STUFF HOSPITALS are MADE OF!

CORREGIDOR

Out of the war tragedies of Bataan and Corregidor, Hong Kong, Singapore, Pearl Harbor... and the daily news reports from the world war fronts... come stories of the incredible valor of those who seek no glory—doctors and nurses; pharmacists; ambulance drivers; stretcher bearers; first-aid field personnel.

These are the people who symbolize America's priceless ingredient — the spirit of an unconquerable people in the world's greatest struggle for the triumph of RIGHT over MIGHT.

Those in authority in our Medical Corps; those who give the orders and those who do the actual work of repairing and rebuilding the injured and the sick... these unsung heroes, both men and women, got their training in HOSPITALS! They are the stuff hospitals are made of.

Those of us at home cannot do less than our utmost best to merit, in some small degree, a kinship with these people who have worked side by side with us under happier circumstances.

WILL ROSS, *Inc.*

QUALITY HOSPITAL SUPPLIES

MILWAUKEE WISCONSIN

WITH SPEED AND CERTAINTY

THROW YOUR SCRAP INTO THE FIGHT

Dietitians Slant Convention Toward War-Time Nutrition

All sessions of the Detroit convention of the American Dietetic Association, October 19 to 22, are being planned so as to provide the dietitian with the greatest possible aid in playing her part under war circumstances.

Plans for increasing the number of trained dietitians available for Army service as well as for civilian service will be discussed.

The best methods of teaching nutrition to the public and the most effective means by which the dietetic profession can be of help to the Red Cross will be studied at this meeting. Ways of helping the dietitian serve most effectively in hospitals, schools and industrial cafeterias will also be studied.

Celebrates Ninety Years' Service

Since Mount Sinai Hospital, New York City, opened 90 years ago, Mount Sinai physicians have treated 350,000 patients without pay. The hospital's current annual report is a commemorative volume with photographs and drawings illustrating the contrast between the institution in its earlier days and at present.

New Training Centers for Nurses Will Form, McNutt Announces

WASHINGTON, D. C.—With the Army and Navy calling for increasingly large numbers of graduate nurses for war service, Federal Security Administrator Paul V. McNutt announced on August 6 plans for spending the $3,500,000 appropriation for nurse training. In addition to the expansion of present facilities for nursing education, new training centers will be established in strategic areas throughout the country in connection with colleges and universities where centralized teaching programs can be developed.

Alma C. Haupt, executive secretary of the subcommittee on nursing of the health and medical committee, pointed out that not only will these training centers accommodate more students and effect an economy in teaching personnel but better teachers can be obtained. In the last fiscal year, 240 schools have been enabled through federal appropriations to increase their enrollment by more than 5000 students. Scholarship tuition and entrance fees are provided in certain cases.

Some 55,000 young women must enroll in schools of nursing by July 1, 1943, and 65,000 by July 1, 1944. New students admitted the year ending June 30 total 45,000.

Refresher courses will be given for inactive nurses and postgraduate courses in special fields will be provided.

To stimulate a large scale enrollment of student nurses in accredited schools of nursing the Office of War Information has given nursing an "A" priority rating on radio time allocated to government programs.

Financed by Immediate Taxation

The new Floyd County Hospital, near Rome, Ga., opened its doors in July. The institution is also a medical center and houses the county board of health and city and county public clinics. Structurally, the new plant consists of five one story buildings connected by a central corridor. It accommodates 65 white patients, 15 colored patients and 15 infants. Financing was by immediate taxation; no bonds were sold and no federal or state grants were applied for.

University to Supervise Infirmary

Direction of the Illinois Eye and Ear Infirmary, Chicago, has been transferred to the University of Illinois School of Medicine by Governor Dwight L. Green, following the recommendation of a committee of the Institute of Medicine which studied the problem at the governor's request.

Government Contracts With Outside Standardizing Agency

Development of standards that will save materials, make fuller use of the nation's production facilities and make price control more effective by pegging price to quality will be spurred by a new contract between the government and the American Standards Association.

Under the terms of the contract, the American Standards Association will develop emergency standards in connection with W.P.B. and O.P.A. war-time supply and price control measures and will be reimbursed by the government for the actual cost of the work involved.

Hospital Visitors Faint at Movies

Too late to catch the National Hospital Day report in the June issue but not too late to record, through the courtesy of the Missouri Hospital Association bulletin, is the news that 25 persons fainted during that day at Presnell Hospital, Kennett, Mo., while or after watching motion pictures of operations or examining surgical instruments.

Peralta Fixes Limits on Postoperative Stay of Uncomplicated Cases

Because of increasing demand for hospital services and overcrowding of the hospital, the medical advisory board of Peralta Hospital, Oakland, Calif., has adopted limits on the postoperative stay of uncomplicated surgical cases.

To cite a few applications of the rule, appendectomy is six days; cesarean section, eight days; curretage and dilatation, one day; hemorrhoidectomy, two days; hysterectomy, eight days, and hernia, six days. It is recommended that major surgical cases be sent home by ambulance.

For medical cases, physicians "are respectfully requested to discharge such cases when further care can be rendered in the home and not to hospitalize cases that may be treated at home or to hospitalize patients whose diagnostic studies could be conducted in the doctor's office."

The medical advisory board and the surgical committee declare that "the hospital today must be regarded as an institution for the care and treatment of the critically ill. We have had to streamline our organization, eliminating the frills of service, in order that your patient may receive adequate nursing care."

Attending Cornell's Hotel Course

A dozen or more hospital persons are enrolled in the 1942 session of the summer school of hotel administration at Cornell University. Among them are: Alma Blum, Niagara Sanatorium, Lockport, N. Y.; Jane M. Boyd, Homeopathic Hospital, West Chester, Pa.; Myron S. Burton, Shadyside Hospital, Pittsburgh; Charles R. Clark, Bergen Pines Hospital, Ridgewood, N. J.; Arthur W. Harvey, Western Pennsylvania Hospital, Pittsburgh; Rose Jacobs, Citizens' Hospital, North Barberton, Ohio; Laura A. Ott, Tioga County Hospital, Waverly, N. Y.; Eva R. Ransom, Lee Memorial Hospital, Fort Myers, Fla.; Isabel M. Reardon, Colorado State Hospital, Pueblo; Helen B. Ross, Tompkins County Memorial Hospital, Ithaca, N. Y., and Thomas A. Tonge, City Hospital, Paterson, N. J.

College Nursing Degree at Dillard

A strictly collegiate school of nursing is being introduced at Dillard University, New Orleans, on September 14. The plan provides for academic instruction leading to a university degree and a diploma in nursing at the university and for professional instruction and experience at Flint-Goodridge Hospital, Charity Hospital and other health and social welfare agencies in the city.

Federal Grant Builds Health Center

St. Louis County Hospital, Clayton, Mo., of which Dr. Curtis H. Lohr is administrator, has received a federal grant of $522,000 for a health center to be erected on the hospital grounds. The grant represents the full cost of the structure.

Nation Short 60,000 Doctors

Selective Service officials estimate that the country needs 140,000 doctors to perform both military and civilian functions. The nation has 80,000 doctors. During the next three years 21,029 students will be graduated from approved medical schools, according to the *Journal of the American Medical Association*. This is the largest number ever to have been turned out by U. S. medical colleges in a three year period and is made possible by the adoption of accelerated programs.

Spaulding Heads N. H. Plan

A Blue Cross plan for the state of New Hampshire is in process of formation and, last month, R. S. Spaulding was employed as executive director. Mr. Spaulding has been in the public relations department of the Massachusetts Hospital Service, Inc.

New Jersey Hospitals Obtain Increase in Compensation Rates

Hospitals in New Jersey are to be paid $5.50 per day for the first seven days and $5.25 per day thereafter for the care of workmen's compensation cases in place of the $4.50 per day that they formerly received, according to a decision of the state department of labor announced last month.

This important improvement in rates was obtained by a committee headed by F. Stanley Howe of Orange Memorial Hospital. The committee had asked for $6 per day, but the insurance carriers objected to this rate. The new rates are to be effective retroactively to March 1, 1942.

In his decision on the matter the commissioner of labor stated that "to deny the hospital proper economic support may create a greater havoc to public safety and health. I do not see how we can permit the financial structure of so many hospitals to be further weakened by a loss of necessary income in order to operate properly."

Is Foundation's First Project

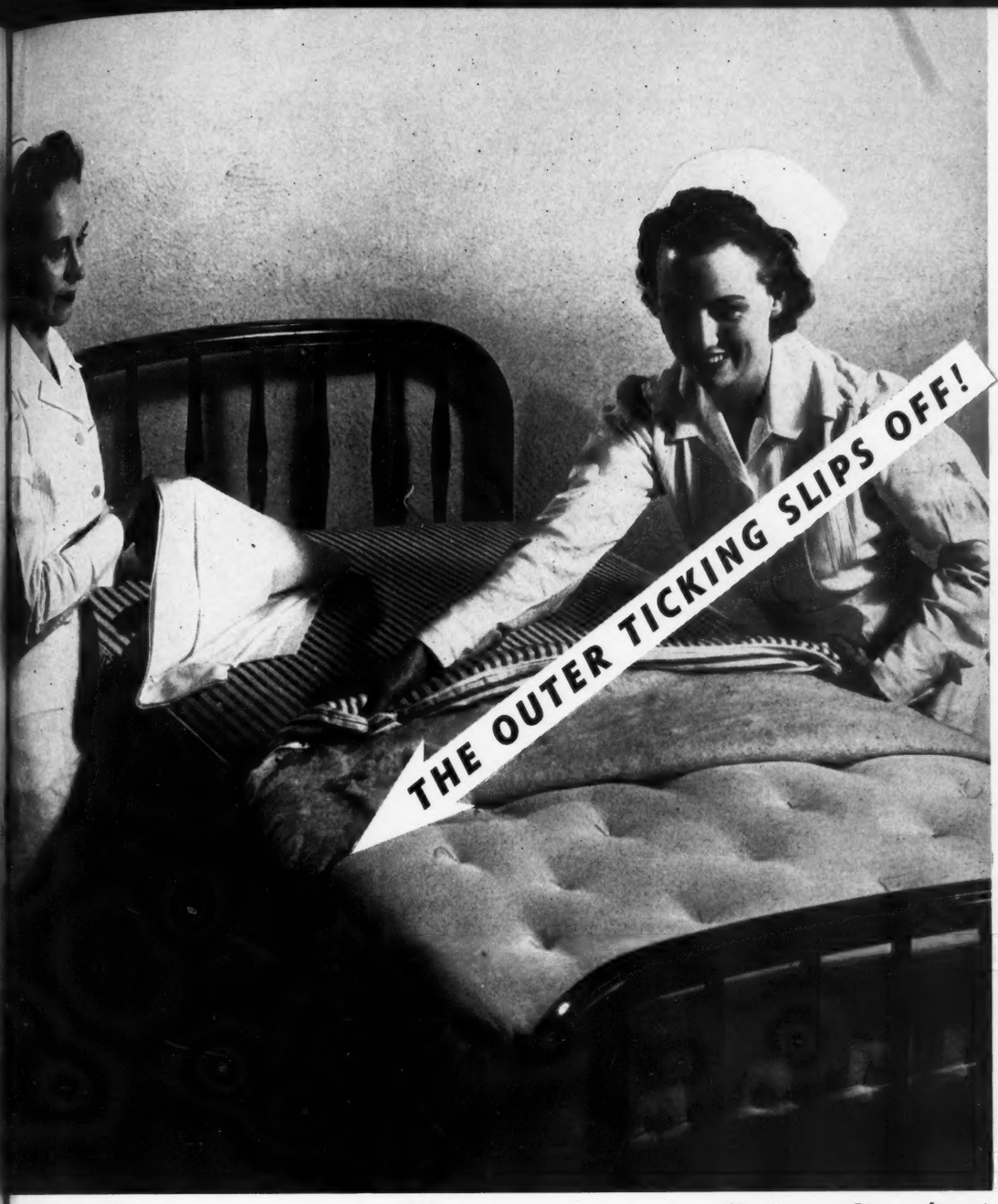
The first project of the new John Morse Memorial Foundation, Madison, Wis., will be the establishment of a hospital and nursing school at Beloit, Wis., site of one of the Fairbanks, Morse & Co. plants. The foundation to "promote, assist and make donations to existing charitable, benevolent, scientific, religious, literary and educational enterprises, as well as to its own institutions of this nature" has recently applied for a charter. Col. R. H. Morse, president of the company, filed the application.

New York Department Speeds Nurses

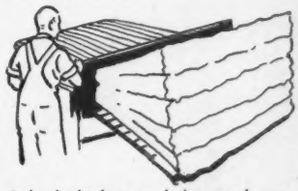
One hundred prenursing students of New York City's Department of Hospitals were admitted to Brooklyn College on June 29 for two months' preclinical science work before being admitted to Bellevue, Harlem, Kings County and Metropolitan hospitals in September to continue their nursing program. This arrangement was made possible by a grant under the Federal Security Agency Appropriation Act of 1942.

Aids in Training Physical Therapists

Grants for providing scholarships and training in physical therapy have been given to the following institutions by the National Foundation for Infantile Paralysis, according to a recent announcement: D. T. Watson School of Physical Therapy, $4500; American Physiotherapy Association, Stanford University, $5000; School of Health, Stanford University, $6920, and Northwestern University Medical School, $3800.

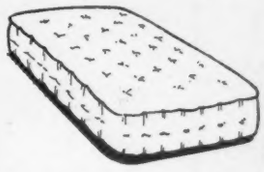


The outer ticking unlaces at the end and slips off easily for dry cleaning or replacement. This ticking has no tufts or rolled edges to collect dust and dirt, or to wear and fray; a smooth sleeping surface for maximum comfort.



Only the highest grade long-staple new Texas cotton is used in the all-cotton Morning Glory. And generous amounts of it, too, manufactured into fluffy batting by the Taylor-made "layer-bilt" process, giving unequalled softness, resiliency and long wear.

Center crowning, a special Taylor-made process, resists permanent indenture where the body lies heaviest. Five layers of batting are laid atop each other, the middle layer diagonally across the mattress, giving maximum strength and resiliency.



The inner ticking is permanently tufted to the cotton batting. Each tuft is permanently anchored in place to preserve uniformity by preventing "crawling," lumping or spreading. For this reason, Morning Glory mattresses hold their shape and always look trim and neat.

SAVE *Time* . . . SAVE *Money* . . . ADD *Extra Comfort* WITH THE MORNING GLORY HOSPITAL MATTRESS

Long life, easy handling, unmatched cleanliness, plus real comfort—that's the Morning Glory, the world's only hospital mattress designed by hospital men and built to stand up under hospital conditions. With removable ticking (which alone doubles its life) the Morning Glory can be sunned with ticking removed and come back with new life and fluffiness—virtually a new mattress. Taylor-made's laminated construction resists indenture of the hips where the body lies heaviest—helps the Morning Glory keep its shape and retain its comfort. And speaking of comfort, the scientifically designed and master-built Morning Glory just hasn't a rival. From dozens of hospitals have come reports that unsolicited comments of approval are frequently received from patients. When it's mattress buying time for you, see for yourself how the Morning Glory will save you time, save you money, and add extra comfort to your beds—see the mattress that hospital men designed to help solve your mattress problems. Write to the Taylor Bedding Manufacturing Company—the world's largest bedding plant—for complete information and an estimate based upon your own requirements. No obligation on your part, of course!

E *Morning Glory*
HOSPITAL MATTRESS

Manufactured by
TAYLOR BEDDING MANUFACTURING COMPANY ★
The World's Largest Bedding Manufacturers
TAYLOR, TEXAS

Morning Glory is also available in the innerspring style, with many of the tures of the all-cotton Morning Glory, plus extra bouyancy and resiliency sible only in a good innerspring mattress.

★ *WRITE TODAY FOR COMPLETE DETAILS* ★

Taylor Bedding Mfg. Company
Taylor, Texas

Gentlemen: Without obligation please send me complete information, including prices, on your Morning Glory hospital mattress.

*Name of Institute*_____

*Address*_____

*City*_____ *State*_____

*Number Beds:*_____ *Number Mattresses Needed:*_____

*Size:*_____ *Cotton or Innerspring Style?*_____

*Requested by*_____

Coming Meetings

Sept. 9-12—American Congress of Physical Therapy, Hotel William Penn, Pittsburgh.

Sept. 14-26—A.H.A. Institute for Hospital Administrators, International House, University of Chicago, Chicago.

Oct. 12-16—American Hospital Association, St. Louis.

Oct. 19-22—American Dietetic Association, Hotel Statler, Detroit.

Oct. 21-24—Conference on Venereal Disease Control in War Time, auspices of U. S. Public Health Service, Arlington Hotel, Hot Springs National Park, Arkansas.

Oct. 26-31—American Public Health Association, St. Louis.

Nov. 5-6—Maryland-District of Columbia Hospital Association, Carvel Hall, Annapolis, Md.

Nov. 17-20—American College of Surgeons, Hospital Standardization Conference, Auditorium, Cleveland.

1943

Feb. 18-19—Texas Hospital Association, Texas Hotel, Fort Worth.

March 10-12—New England Hospital Assembly, Hotel Statler, Boston.

April 14-16—Hospital Association of Pennsylvania, Bellevue-Stratford Hotel, Philadelphia.

April 27-29—Ohio Hospital Association.

May 5-7—Tri-State Hospital Association, Palmer House, Chicago.

Form Aerial Transportation Unit for Wounded Soldiers

WASHINGTON, D. C.—The War Department announces the organization of a unit to be known as the Air Evacuation Group (Medical) which will provide complete facilities for treatment in transit during the aerial transportation from theaters of war of sick and wounded military personnel. The unit will use transport planes, which will be equipped with fittings for racks and supports to accommodate standard Army litters and will be able to carry as many as 40 patients.

They will have facilities for surgical teams and for blood transfusions and the use of plasma, as well as medicines, stimulants and sedatives, vacuum jugs for liquids and chemical heating pads. Each evacuation will be under the supervision of a flight surgeon and each plane will carry an Army nurse and one trained medical corps enlisted man to care for patients. Nurses are required to have air experience before they will be accepted for this service.

Rhode Island Workers to Get Cash for Days Lost While Sick

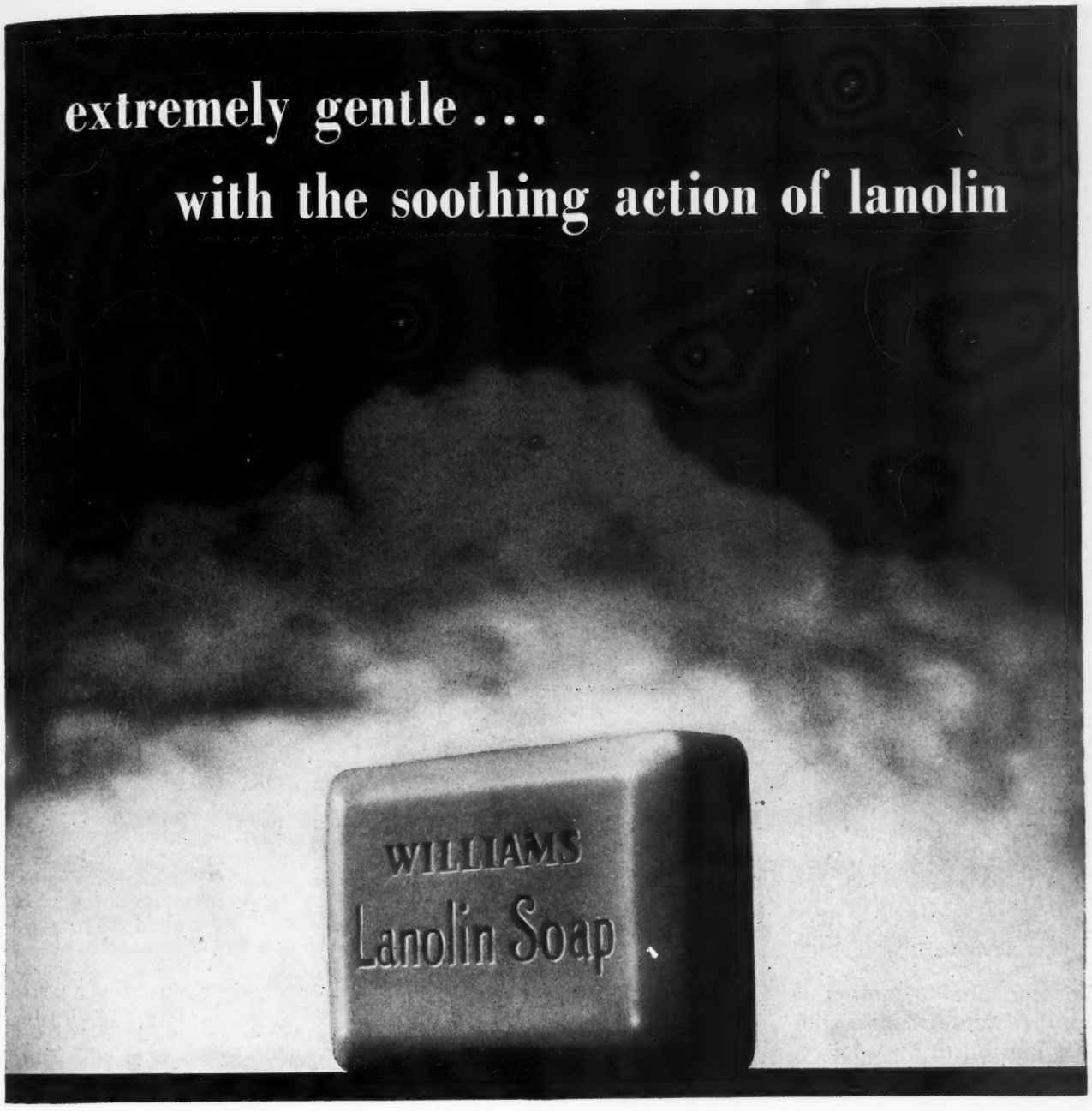
By a law enacted in May, Rhode Island becomes the first American state to establish a cash benefit system to compensate for wages lost due to sickness. Workers eligible under the act will, after a one week waiting period, receive payments ranging from $6.75 per week to $18 per week, depending upon the wage rate. Wage deductions began on June 1 and benefits will begin next April 1. The administration of the law will require the services of physicians to certify to disability. The medical profession is cooperative toward the new law.

Mercy Campaign Oversubscribed

A public campaign to complete the building fund for the new Mercy Hospital of Portland, Me., has been oversubscribed. The Sisters of Mercy, who now conduct Queen's Hospital, borrowed half a million last year and began construction. A federal appropriation of $239,000 under the Lanham Act has been made and $300,000 was raised in almost 7000 subscriptions from residents of all denominations. Edward T. P. Graham of Boston is the architect. Will, Folsom and Smith, Inc., of New York conducted the campaign.

Leominster Gets Large Bequest

Under the will of the late Dr. Frederick C. Shultis, the Leominster Hospital, Leominster, Mass., will receive the sum of $200,000, Shannah N. MacFadden, the superintendent, reports.



Extra-bland soaps have been our specialty for over 100 years—Williams famous shaving soaps.

Now we use this experience to make an exceptionally mild toilet soap. And, for added gentleness, we include soothing lanolin in the formula.

Williams Lanolin Soap is made with the finest quality oils on the market . . . used liberally, and in a way that precludes rancidity. No fatty acids are present, no dye, no strong perfume. Uncombined alkali is virtually non-existent.

Pay what you will, we don't believe you will find a soap that is more gentle to dry or irritated skin, to the sensitive skin of infants.

Colorfully wrapped, delicately scented, creamy-lathering—Williams Lanolin Soap delights patients. For economy, each cake is subjected to high pressure; it is a very *lasting* soap.

So that you can observe its qualities in actual use, we'd like to send you a full-size cake of Williams Lanolin Soap. Just mail the coupon. (Send your home address, if you wish.) There's no obligation, of course. Offer good in the U. S. A. only.

The J. B. Williams Co., Dept. SB-3,
Glastonbury, Conn., U. S. A.

Gentlemen: I'll be glad to accept your offer of a full-size cake of Williams Lanolin Soap.

Name_____

Street_____

City_____ **State**_____

Hospitals to Revise Lists of Essential Staff Members

WASHINGTON, D. C.—Hospitals must furnish the War Manpower Commission with a revised list of essential hospital staff members, owing to the many changes in intern and resident appointments since July 1 and to the urgent need of the armed forces for young medical officers.

Many hospitals can and should make further reductions from their original lists of essential personnel, the directing board of the Procurement and Assignment Service contends. Ten procedures and criteria to be used in revising the lists are being sent to hospitals with the new survey forms.

Essential positions should be filled as far as possible by women, physically ineligible younger men, and older men.

Stoker Priority for Seaboard Hospitals

WASHINGTON, D. C.—Hospitals in the vital seaboard areas wishing to purchase stoker equipment to convert their heating systems from oil to coal will have their priority applications passed on favorably, according to news last month from the Bureau of Governmental Requirement.

Graduates in Administration Get Internship Appointments

The 1942 graduates of the course in hospital administration at the University of Chicago are taking administrative internships in various hospitals from coast to coast.

Andrew Pattullo is at Orange Memorial Hospital, Orange, N. J. Robert Youngquist is at the Hospital of the Protestant Episcopal Church, Philadelphia. Polly Hunt is at St. Luke's Hospital, New York City. Sidney Liswood is at New Haven General Hospital, New Haven, Conn. Richard Highsmith is at Evanston Hospital, Evanston, Ill. James Sexton is at Peralta Hospital, Oakland, Calif. After six months Mr. Sexton will go to Samuel Merritt Hospital and then later to Alameda County Hospitals.

Ernest Bliss was drafted before he was able to take his internship but expects to be assigned to hospital work.

Charles Burbridge has been appointed as assistant to Dr. John Lawlah, dean of Howard University Medical School, who has recently taken over the direction of Freedman's Hospital in Washington, D. C.

University of Texas Plans Great Expansion Program

The University of Texas is expanding its medical school, enlarging its college of nursing, establishing a state school of dentistry, including its present college of pharmacy, developing the cancer research and hospital program approved by the legislature and planning on increased activity in the fields of public health and preventive medicine.

This large program is to be administered under the supervision of a general director, who is to be given the title of university vice president. As we go to press, President Homer P. Rainey and the board of regents have not yet announced the name of the appointee to this important post.

To Restrict Enamel Ware Sizes

WASHINGTON, D. C.—Of 150 different sizes of enamel ware for hospital use, manufacturers will be limited to production of only 11 types, it is expected. Dressing jars are given as a typical example. The ultimate limit will be two sizes—a 2 to 2½ quart and a 4 to 4½ quart.

Hospital Has Stratosphere Tank

Research in aviation medicine is being carried on at St. Luke's Hospital, Chicago, where on the second floor a high altitude test chamber has been built, the gift of the Chicago Bridge and Iron Company. Other commercial companies have donated essential equipment for the research project.

Names in the News

Administrators

William E. Barron, superintendent of Washington Hospital, Washington, Pa., reported for duty at Camp Croft, S. C., August 1 as Colonel Barron of the infantry reserve.

Dr. Albert G. Engelbach, director of Cambridge Hospital, Cambridge, Mass., reported for active duty as major in the Army Medical Corps on July 25. He is on leave of absence from the hospital. **Dr. Frederic A. Washburn** has resumed the directorship and has named **N. Conant Faxon** as assistant director of the hospital.

Dr. Carl Apfelbach, director of the department of pathology at Presbyterian Hospital, Chicago, has been appointed medical director of the hospital. **Dewey Lutes** has resigned as superintendent, since that post now becomes subsidiary to the medical directorship. His resignation becomes effective August 31. **Asa S. Bacon,** superintendent emeritus, will continue in that capacity and as a consultant. Mr. Lutes is one of the founders of the A.C.H.A. and served as its executive secretary for a number of years.

Dr. John West, executive officer of Provident Hospital, Chicago, has been commissioned a major in a medical unit on duty in one of the southwestern states.

Robert Snitzer, a graduate of the University of Chicago course in hospital administration, who recently completed an administrative internship at Orange Memorial Hospital, Orange, N. J., has been appointed a second lieutenant in the 6th Evacuation Hospital (Roosevelt unit) and has reported for duty.

Stanley A. Ferguson, administrator of Chicago Lying-In Hospital, has gone into active service as a captain in the 25th Evacuation Hospital (West Suburban unit). He is succeeded by **H. A. Barth,** a graduate of the University of Chicago course in hospital administration, who has been appointed assistant to the director of the University of Chicago Clinics. Mr. Barth has been taking his administrative internship under Doctor Bachmeyer and Doctor Whitecotton at the university clinics.

E. R. Snyder, formerly assistant superintendent of Wesley Hospital, Chicago, has been named superintendent of Elmhurst Community Hospital, Elmhurst, Ill., to succeed **Dr. Martin F. Heidgen,** medical superintendent, who recently has been called into active duty as a captain with the 25th Evacuation Hospital. Mr. Snyder will serve as superintendent for the duration of Doctor Heidgen's military service.

R. M. Porter, since 1936 assistant administrator of Akron City Hospital, Akron, Ohio, is the new superintendent of Children's Hospital, Columbus, Ohio.

Newton Fisher has resigned as superintendent of James Walker Memorial Hospital, Wilmington, N. C.

Mother Corinna has been appointed Superior of Columbus Hospital, Philadelphia.

Blanche Smith, R.N., has assumed the duties of superintendent of City Memorial Hospital, Thomasville, N. C.

Mrs. Annie Laura Farkas has been selected as the new superintendent at Phoebe Putney Memorial Hospital, Albany, Ga., with **Mrs. Clara Spence** as assistant superintendent.

Frances Conrad recently replaced **Louise Jeffcoat** as superintendent of Davidson Hospital, Lexington, N. C.

Mrs. Garnett L. Radin resigned recently as head of Indian River Hospital, Vero Beach, Fla. She has been succeeded by **Mary A. Poole.**

Hope Hackett has been appointed superintendent of Belmond Hospital, Belmond, Iowa.

Alma Gaudet was recently named to succeed **Edna Seaman** as superintendent at Parsons Hospital, Flushing, N. Y.

Sister M. Monica is now head of Bastrop General Hospital, Bastrop, La.

Mary C. Schabinger assumed the position of superintendent of De Ette Harrison Detwiler Memorial Hospital, Wauseon, Ohio, on August 1.

Amelia E. Ditt, R.N., recently became head of Community Hospital, Big Rapids, Mich.

Earl F. Mitchell was recently appointed superintendent of Lockport City Hospital, Lockport, N. Y.

Dr. H. R. Lyddon Jr. took over the superintendency of Bethany Hospital, Bethany, Mo., on August 1.

F. Hazen Dick, purchasing agent at the University of Michigan Hospital, resigned recently to become superintendent of City Hospital, Louisville, Ky.

Bernard P. Daxon, superintendent of the Nebraska State Hospital for the Tuberculous, Kearney, Neb., resigned recently to enter defense engineering work. **Hugo Carroll** is his successor.

Honor Roll

Hospital administrators and assistant administrators serving in the armed forces:

U. S. Army

William E. Barron (Col.), Washington Hospital, Washington, Pa.
Dr. Albert G. Engelbach (Maj.), Cambridge Hospital, Cambridge, Mass.
Stanley A. Ferguson (Capt.), Chicago Lying-In Hospital and Dispensary, Chicago.
Dr. Martin F. Heidgen (Capt.), Elmhurst Community Hospital, Elmhurst, Ill.
Dr. M. C. Overton Jr., Worley Hospital, Pampa, Tex.
Albert Scheidt (Capt.), Miami Valley Hospital, Dayton, Ohio.
Dr. John West (Maj.), Provident Hospital, Chicago.

Department Heads

E. Virginia Reilly recently assumed the duties of superintendent of nurses at Rockingham Memorial Hospital, Harrisonburg, Va.

Herbert C. Jensen, formerly auditor of the Stevens Hotel, Chicago, has been selected as auditor of Wesley Memorial Hospital, Chicago. At the same time hospital officials announced the appointment of **Vergie Shoup Michael, R.N.,** as assistant director of the school of nursing, and of **Emma L. Grimm, R.N.,** as assistant director of nursing service.

Edna Groppe, R.N., director of the school of nursing at Cook County Hospital, Chicago, recently joined the 27th Evacuation Hospital, University of Illinois Unit, as chief nurse.

Mabel McVicker, R.N., formerly director of nursing and principal of the school of nursing, Waterbury Hospital, Waterbury, Conn., has accepted a similar position at Newton Hospital, Newton Lower Falls, Mass., succeeding **Fay Crabbe.**

Dr. Charles W. Duval has been appointed pathologist and director of laboratories of San Jose Hospital, San Jose, Calif. He was formerly professor of pathology and bacteriology at Tulane University.

Rita E. Miller, R.N., formerly educational director of Mercy Hospital School of Nursing, Philadelphia, has been appointed chairman of the division of nursing at Dillard University, New Orleans.

Sister Antonio, who has been director of nurses of St. Paul's Hospital, Dallas, Tex., has been appointed administrator to succeed **Sister De Paul,** who has been transferred.

Deaths

Dr. Charles E. Rowe, superintendent of Syracuse State School, Syracuse, N. Y., since 1931, died on July 30.

Texas Hospitals Gain From Blue Cross

Group Hospital Service of Texas has increased its payments to hospitals, effective as of July 1, as follows: emergency room treatment increased $2 per day; obstetric cases increased 75 cents per day; one day stay cases in private rooms increased by $5.75 and in ward accommodations by $3.75. The flat rate reimbursement to participants receiving care in hospitals outside the state will be the same as the per diem payment to member hospitals.

Stewardess Qualifications Revised

Although the major airlines recently waived the registered nurse requirement for stewardess work, nurses will be given employment preference if they still wish flying positions, it has been announced. The recent waiver of the "R.N." qualification for sky stewardesses was made in deference to the war-time need for trained nurses.

Dedicates Addition, Changes Name

MacNeal Memorial Hospital, Berwyn, Ill., formerly Berwyn Hospital, dedicated its new addition on June 28. This community hospital was originally a private institution founded by Dr. Arthur MacNeal and in a contest conducted last year to find a suitable name for the expanded hospital the community chose to honor this unselfish pioneer. An attractive booklet on this hospital serving the southwest suburban area of Chicago has been published.

St. Luke's Gets Objectors

Maj. Gen. Lewis B. Hershey, director of Selective Service, ruled last month that conscientious objectors to military service may be assigned to work at Presbyterian Hospital, New York City, according to an Associated Press report.

Resort Hotels Now Army Hospitals

Two prominent resort hotels are being converted to hospitals for the Army, according to reports last month. They are the Greenbrier at White Sulphur Springs, W. Va., and the Haddon Hall at Atlantic City, N. J.

Shows War-Time Health Services

A film "Health for Victory," released in early July, depicts Hadassah Medical Center at Mount Scopus, Jerusalem, group hospitalization, child welfare and other public health services in Jerusalem as they are now organized for the war effort. The film is released by Hadassah, the women's Zionist organization of America.

State Winners in Hospital Day Contest

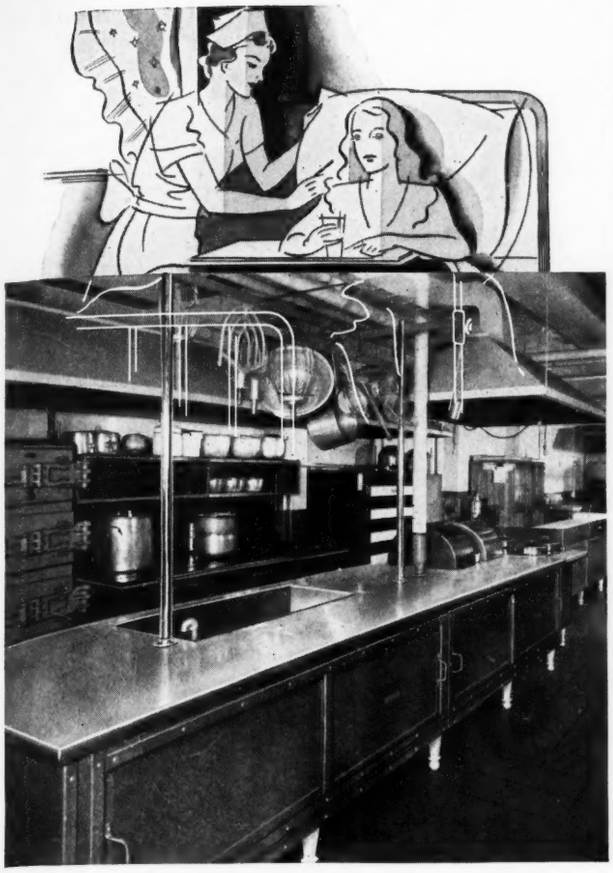
For their National Hospital Day observances, the Association of California Hospitals has given first award for cities of more than 15,000 population to the Collis P. and Howard Huntington Memorial Hospital, Pasadena, and for cities of less than 15,000 population to Lindsay Municipal Hospital, Lindsay. Honorable mention was given to Orthopaedic Hospital, Los Angeles.

Gets Half Million in Property

The Deaconess Hospital, Spokane, Wash., became full owner last month of real estate valued at about $500,000. One half interest in this property had been left to the hospital by Dr. Theodore Chamberlin of Concord, Mass., who died in 1939. The other half was received from his brother, Gardner B. Chamberlin of Spokane, who died June 1. The property will be named for a third brother.

Teague Writes as Well as Draws

Walter Dorwin Teague, famous industrial designer who designed both the former and present cover of The MODERN HOSPITAL, is co-author with Ruth Mills Teague of a new murder mystery, "You Can't Ignore Murder." The characters are international architects.



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Books on Review

ADMINISTRATIVE MEDICINE. *Edited by Haven Emerson, M.D. New York: Thomas Nelson and Sons,* 1941. *Pp.* 839.

Doctor Emerson, with the collaboration of 56 authors, has edited a splendid treatise upon those phases of organized medical services in which are involved, as the editor states, "the skills and efforts of a number of persons related to each other by authorized organization, be it institutional or agency, for the delivery of service to individuals and groups or to whole communities or national populations."

The work is divided into three main divisions: the organized care of the sick; public health services, and inclusive medical care for prevention and treatment. Major divisions are appropriately subdivided into chapters, each of which has been written by a competent, recognized authority in his respective field.

In so large a field, it is impossible to discuss the multitude of subjects in great detail. Each author, however, has presented a comprehensive summary of the principles underlying the particular phase of the field assigned in excellent manner.

The book will be of interest to all workers in the field of organized medical services; it will be of great value to students preparing for careers in medical administration and would also be helpful (if they will only read it) in broadening the knowledge and appreciation of the members of the medical profession of the principles and mechanics involved in furnishing medical care to the public under the conditions and circumstances of the present day. Instructors in medical colleges, in charge of courses on medical economics, would do well to call this splendid volume to the attention of their classes.—ARTHUR C. BACHMEYER, M.D.

VITAMINS AND MINERALS FOR EVERYONE. *By Alida Frances Pattee. New York: G. P. Putnam's & Sons,* 1942. *Pp.* 242. $2.

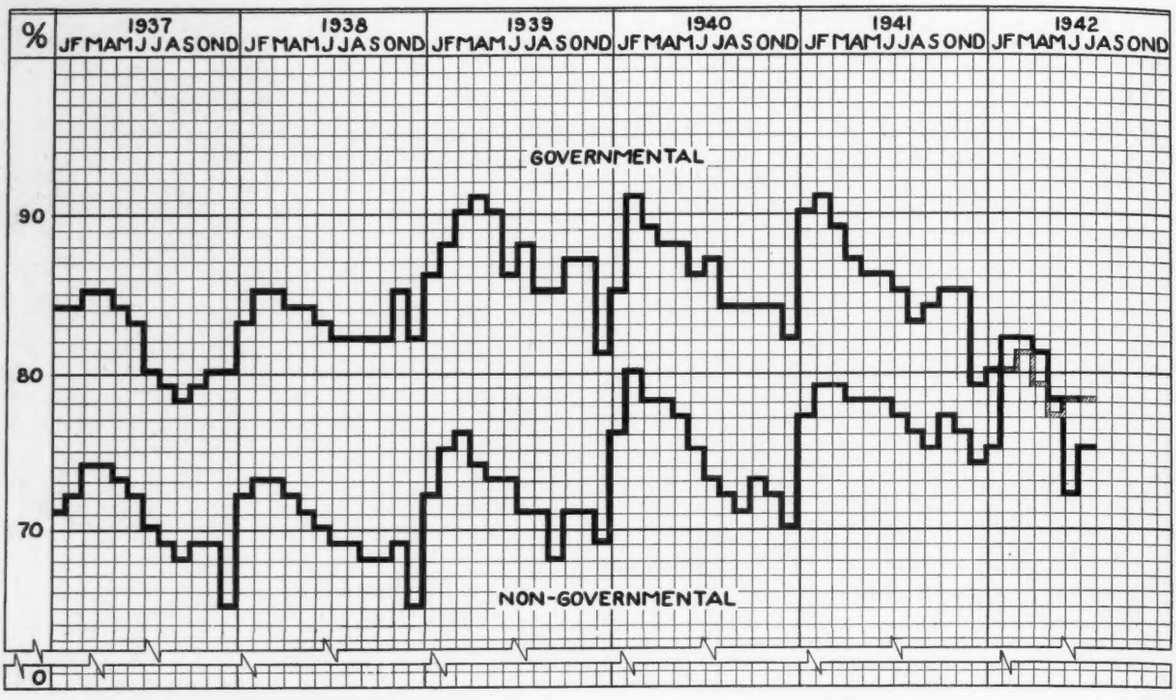
The author has chosen the difficult task of presenting a book for the use of two widely divergent groups, the laity and the professionally trained person. The tables that give the vitamin and mineral content of foods in terms of household measures as well as weights are extensive and will be a valuable addition of this type of material for the professional groups. At the same time the arrangement of this material into tables in order of concentration of vitamins makes them usable and convenient for the less technically trained individual.

The information in regard to vitamins and minerals in the question and answer form is a simple and graphic method for handy reference.

It is most unfortunate, however, that the foreword reads like a patent medicine advertisement and that the stories from real life illustrating vitamin or mineral deficiencies illustrate rather the shotgun methods of diagnosis and therapy so often applied to nutrition problems. They are misleading to the lay person and unconvincing to the scientific mind.

Until more reliable data are presented as to the incidence of subclinical and actual deficiency states, simple methods of diagnosis developed and more complete vitamin content of food stuffs known, statements as to widespread deficiencies or brilliant and extensive cures by vitamin therapy, unless made with great care, lead to the widespread use of nostrums rather than to wise food selection.—KATE DAUM, Ph.D.

Occupancy Continues High in Voluntary Hospitals



High occupancy in voluntary hospitals was recorded again for July, with a drop in use of governmental institutions. New Orleans, San Francisco, St. Paul and Cleveland all reported nongovernmental occupancies of 80 per cent or more for the month.

Sixteen new hospital construction projects were announced between July 13 and August 10, bringing the year-to-date total to $108,473,000 compared to $82,650,000 last year. During the four week period, however, war stopped work on 27 previously announced projects valued at $10,527,000.